JEFFREY J. GONDA, WSB #5-1593
LONABAUGH & RIGGS, LLP
50 East Loucks Street, Suite 110
P.O. Drawer 5059
Sheridan, WY 82801
Telephone: (307) 672-7444
Facsimile: (307) 672-2230

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF WYOMING

STEVEN DUFFY, Plaintiff, vs. SHEFFIELD, OLSON & MCQUEEN, INC., a Minnesota corporation, and FIRST CHOICE OF THE MIDWEST, INC., a South Dakota corporation, Defendants.	CIVIL NO. 12-CV-197-SWS

COMPLAINT

Plaintiff, by and through his attorneys of record, and for his claims for relief against the Defendants named above, alleges and states as follows:

PARTIES TO THE ACTION

1. Plaintiff, Steven Duffy, is a resident of Gillette, Wyoming. At times material to the facts alleged in this Complaint, Plaintiff was employed by Farmers Cooperative Association Gillette, Wyoming ("FCA"). As such, Plaintiff was eligible for health insurance coverage, and

received health insurance coverage, under the Farmers Cooperative Association Employee Medical Benefit Plan (the "Plan").

2. Defendant Sheffield, Olson & McQueen, Inc. ("SOMI") is a Minnesota corporation domiciled in Minnesota and conducting business in the state of Wyoming, and at all times relevant hereto was the "Contract Administrator" for the Plan.

3. Defendant First Choice of the Midwest, Inc. is a South Dakota corporation domiciled in South Dakota and conducting business in Wyoming, and is the "Medical Management Services Provider" for the Plan.

JURISDICTION AND VENUE

4. This Court has jurisdiction over the claims asserted by the Plaintiff pursuant to 29 U.S.C. §1132(e)(1).

5. Because the Plaintiff's Medical Benefits Plan (the "Plan") was administered, in part, in this district, and the breach of that Plan took place in this district, and because Defendants do business in this district, venue in this Court is proper under 29 U.S.C. §1132(e)(2).

STATEMENT OF FACTS

6. At all times material to the facts alleged herein, Plaintiff, as a qualified employee of FCA, was continuously insured under a self-funded group medical benefits policy issued and partially administered by FCA. As such, the Plan was governed by the terms and provisions of the Employers Retirement and Income Security Act of 1974 ("ERISA"). A copy of the group insurance policy is attached hereto as **Exhibit A**.

7. The insurance contract was administered by Sheffield, Olson & McQueen, Inc. ("SOMI"). Under the Plan, FCA designated SOMI to decide claims.

8. The Plan also required that all claims decisions be certified by the Medical Management Services Program. On Plaintiff's best knowledge and belief, the Medical Management Services Program was Defendant First Choice of the Midwest, Inc. ("First Choice").

9. On or around May 9, 2011, Plaintiff underwent surgery on his neck and low back at the recommendation of Dr. John Schneider, a Board Certified Neurosurgeon.

10. Prior to surgery, the Plaintiff was suffering from debilitating and chronic pain. Dr. Schneider recommended the surgery because the Plaintiff had multiple levels of serious degenerative change which had continually worsened despite nearly 20 years of chiropractic care.

11. Dr. Schneider's surgery recommendation was supported by multiple consultations with the Plaintiff, by Plaintiff's medical history, and by multiple MRIs.

12. Prior to the surgery, Plaintiff contacted First Choice to obtain pre-authorization for the surgery, as required by his Plan. The person with whom Plaintiff spoke authorized the surgery, but concurrently advised Plaintiff that he did not need to obtain pre-authorization.

13. Prior to the surgery, Dr. Schneider's office also contacted First Choice. First Choice pre-authorized the surgery. *See,* Letter dated 7/18/2011, attached hereto as **Exhibit B**.

14. Plaintiff's Plan states, "A pre-service, urgent care, or concurrent care claim is 'decided' when it is certified by the Medical Management Services Program." *See,* **Exhibit A**, 58.

15. First Choice and/or SOMI remitted payment to Dr. Schneider's office in the amount of Thirty-Nine Thousand, Seven Hundred Seventeen Dollars and Ninety-two Cents ($39,717.92), when Mr. Duffy presented his claim for coverage of the surgery invoices. First Choice and/or SOMI did not pay the other invoices related to Mr. Duffy's surgery.

16. After paying part of the surgery invoices, First Choice and/or SOMI has requested to be reimbursed by Dr. Schneider's office on the grounds that the Defendants now believe the surgeries were not "medically necessary." Defendants deny responsibility for any invoices related to Dr. Schneider's surgery.

17. Plaintiff's Plan defines "Medically Necessary" as:

> Services and supplies provided to a Covered Person which, in the judgment of the Plan Sponsor, (a) are appropriate and consistent with the diagnosis or treatment of the Illness, and (b) are customarily and reasonably recognized as appropriate throughout the Physician's profession, and (c) could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered, and (d) are not solely for the convenience of a Covered Person, Physician, Hospital, or other provider.

See, **Exhibit A**, 13.

18. Plaintiff's surgery was medically necessary under the Plan because: (1) it was appropriate and consistent with the diagnosis or treatment for his illness/medical condition; (2) physicians, including Dr. Schneider, customarily recognize surgery as the appropriate course of

treatment for a diagnosis of serious degenerative change in the neck and back like that which plagued Plaintiff; (3) surgery could not have been omitted without adversely affecting Plaintiff's condition or the quality of medical care rendered; and (4) the surgery was not merely for the convenience of the Plaintiff, doctor, hospital, or other provider.

19. Plaintiff's history of non-operative treatment further shows the surgery was medically necessary because despite nearly twenty (20) years of conservative care, Plaintiff's condition had worsened dramatically by the time he underwent surgery.

20. Between the years 1991 and 2011, Plaintiff was provided non-operative treatment for the pain in his neck and lower back, from various chiropractors, including Dr. Todd A. Hildebrand, D.C., and Dr. Kevin E. Schreiner, D.C. Despite treatment, his condition continued to deteriorate.

21. Prior to treatment by Dr. Schneider, Plaintiff sought treatment from a new chiropractor, Dr. Kim Maycock, D.C., in January of 2011, in hopes of improving his condition. After seven treatments with Dr. Maycock, Plaintiff experienced no improvement in his condition.

22. Because conservative care had failed to help Plaintiff's condition, Dr. Maycock scheduled an MRI at Campbell County Memorial Hospital. Dr. Maycock determined from the MRI that Plaintiff had multiple levels of serious degenerative change in his neck and lower back. For that reason, she referred Plaintiff to Dr. John Schneider, a Board Certified Neurosurgeon, for further care and treatment.

23. Prior to the surgery, Plaintiff was in so much pain that he was in jeopardy of losing his job. Plaintiff's pain had escalated to the point that he was debilitated by sharp, tingling, constant pain in his feet and arms and hands. He was unable to enjoy everyday life and was unable to perform tasks without severe pain that others perform with ease, for example: getting out of bed, tying shoes, and getting into and out of vehicles.

24. After surgery, Plaintiff is able to comfortably perform routine daily activities including those required to perform his job as a delivery driver.

25. The total amount due for invoices related to Plaintiff's surgery is approximately Eighty-Nine Thousand, Nine Hundred Fourteen Dollars and Fourteen Cents ($89,914.14), in addition to the Thirty-Nine Thousand, Seven Hundred Seventeen Dollars and Ninety-Two Cents ($39,717.92) that one or both Defendants paid and now demands back from Dr. Schneider. If this Court does not enter judgment against the Defendants for the amounts due under their contractual obligations for Plaintiff's pre-authorized surgery, Plaintiff will be stuck with unexpected medical bills exceeding One Hundred Twenty-Nine Thousand Dollars ($129,000.00).

26. Plaintiff reasonably relied on the Defendants' representation that his insurance policy would cover the cost of surgery when he decided to have the surgery performed.

27. If Plaintiff becomes responsible for the cost of surgery, he will not only bear the burden of unexpected medical expense, but will also be faced with filing for bankruptcy.

PLAINTIFF'S FIRST CLAIM FOR RELIEF
BREACH OF FIDUCIARY DUTY

28. Plaintiff re-alleges and incorporates herein by reference paragraphs 1 through 27 above as if fully set forth herein.

29. The Defendants are fiduciaries in this action as defined by 29 U.S.C. §1002(21)(A) because they each have discretionary authority in the administration of the plan. *See,* DOL Reg. § 2509.75-8, Q/A D-3; DOL Reg. § 2509.75-8, Q/A FR-16; *McNeese v. Health Mktg. Inc.,* 647 F. Supp. 981, 8 EBC 1154 (N.D. Ala. 1986); *and DOL Advisory Opinion*, 93-23A (Sept. 3, 1993).

30. Defendants have final authority over benefit determinations and are also fiduciaries in that regard. *See,* DOL Reg. § 2509.75-8, Q/A D-3.

31. As fiduciaries, Defendants shall discharge their fiduciary duties to the Plaintiff as set forth in 29 U.S.C. §1104(a) as follows:

> (1) Subject to sections 1103(c) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and –
>
> (A) for the exclusive purpose of:
>
> (i) providing benefits to participants and their beneficiaries; and
>
> (ii) defraying reasonable expenses of administering the plan;
>
> (B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims…

32. Defendants breached their fiduciary duties to the Plaintiff in each of the following respects:

a. Defendants negligently or intentionally misrepresented that Plaintiff had health insurance coverage and thereby induced Plaintiff to undergo surgery and incur approximately One Hundred Twenty-Nine Thousand Dollars ($129,000.00) in medical expenses; and

b. Defendants discharged their duties in their own interests and against Plaintiff's interests by intentionally or negligently discounting evidence of the severity of the Plaintiff's condition, ignoring the opinions of multiple physicians, failing to acknowledge the significance of Plaintiff's medical history, and relying only on medical texts which supported finding against the Plaintiff's claim while discounting medical authorities that supported the medical necessity of Plaintiff's surgery. *See, e.g.*, **Exhibit B**.

33. Accordingly, under the provisions of 29 U.S.C. § 1109, Defendants are liable for all damages and losses resulting therefrom.

PLAINTIFF'S SECOND CLAIM FOR RELIEF
BREACH OF CONTRACT

34. Plaintiff re-alleges and incorporates herein by reference paragraphs 1 through 33 above, as if fully set forth herein.

35. At all times material to the facts alleged herein, Plaintiff was continuously insured under the FCA group medical benefits plan, which is administered by the contract administrator, SOMI. As such, Plaintiff was an intended beneficiary under the group medical benefits plan.

36. The plan terms unambiguously state that the Covered Person must call the Medical Management Services Program for pre-approval of procedures requiring hospital confinement in order for the covered person to receive maximum allowed benefits. *See*, **Exhibit A**, 21-23.

37. The maximum lifetime benefit under the plan is $2,000,000. *See,* **Exhibit A**, 24.

38. After both Plaintiff and Dr. Schneider obtained pre-authorization for the surgery from First Choice, Plaintiff, upon the advice of his surgeon, had surgery on his neck and low back.

39. Thereafter, Dr. Schneider submitted an invoice to First Choice and/or SOMI for his time performing the surgery, and First Choice and/or SOMI approved the claim and remitted payment to Dr. Schneider.

40. Thereafter, First Choice and/or SOMI demanded that Dr. Schneider refund the benefits paid under the contract. The demand for repayment described herein constitutes a total and material breach of the Defendants' duties under the Plan, and is a breach of contract.

41. Defendants' failure to cover the expenses related to Plaintiff's pre-authorized surgery also constitutes a total and material breach of contract.

42. Plaintiff has satisfied all duties and requirements imposed upon him by the Plan and has otherwise fully performed his contractual obligations thereunder.

43. As a result of Defendants' material breach of contract, Plaintiff has sustained damages as set forth in Plaintiff's prayer for relief below, all of which were reasonably foreseeable by Defendants at the time they entered into a contractual obligation with Plaintiff and at the time Defendants wrongfully denied health insurance benefits to Plaintiff.

PRAYER FOR RELIEF

WHEREFORE, the Plaintiff prays for judgment against Defendants for all benefits due the Plaintiff under his health insurance policy, including interest and costs as allowed by law, reasonable attorney's fees as provided under 29 U.S.C. §1132(g)(1), all damages recoverable for breach of fiduciary duty under 29 U.S.C. § 1109(a) as set forth above, and all other damages allowable under 29 U.S.C. §1001 *et. seq.,* in accordance with the allegations of this Complaint.

DATED this 30th day of August, 2012.

LONABAUGH AND RIGGS, LLP

By: _____

Jeffrey J. Gonda, WSB #5-1593
Attorney for Plaintiff
P.O. Drawer 5059
Sheridan, WY 82801
(307) 672-7444
(307) 672-2230 Fax

DEMAND FOR JURY TRIAL

Plaintiff demands a trial by jury on all issues so triable.

DATED this 30th day of August, 2012.

LONABAUGH AND RIGGS, LLP

By: _____

Jeffrey J. Gonda, WSB #5-1593
Attorney for Plaintiff
50 East Loucks Street, Suite 110
P.O. Drawer 5059
Sheridan, WY 82801
(307) 672-7444
(307) 672-2230 Fax

EXHIBIT A

Steve Duffy

Farmers Cooperative Association

Medical Coverage

Farmers Cooperative Association

Plan Document/Summary Plan Description

Group Number: 593

March 2004

Farmers Cooperative Association - #593
Employee Medical Benefit Plan

Amendment #1

Effective February 1, 2005, the Farmers Cooperative Association Medical Benefit Plan, is hereby amended as follows:

1. The term Plan Sponsor and the term Plan Administrator are used interchangeably in this document.

2. Under Definitions, the section titled Out-of-Pocket Maximum has been deleted and replace with the following:

   Out-of-Pocket Maximum - Means the maximum amount of Deductible and Co-insurance a Covered Person and/or covered Dependents must pay for Covered Expenses during a Calendar Year before the Benefit Percentage increases to 100%.

   Expenses incurred for the following will not be applied toward the Out-of-Pocket Maximum: (a) Co-pays; (b) any penalty amounts; (c) any charges defined under Limitations and Exclusions; and (d) Co-pays and Deductibles for Prescription Drugs.

3. Under Medical Management Services, the following section has been added:

   - A request for Pre-admission Review is considered a Pre-service Claim.*
   - A request for an Urgent Review is considered an Urgent Care Claim.*
   - A Concurrent Care Review is treated as a Concurrent Review.*
   - A Retrospective Review is treated as an Urgent Care Claim.*

   * **For further explanation of these terms and the outside time limits for benefit determination, please see the section titled Claims Procedures.**

4. Under Schedule of Benefits, the sections titled Single Coverage Plan and Family Coverage Plan have been deleted and replaced with the following:

Schedule of Benefits	
Benefit	**Payment**
SINGLE COVERAGE PLAN	
• Calendar Year Deductible	$3,000 *
• Benefit Percentage	Deductible and 100%
FAMILY COVERAGE PLAN	
• Calendar Year Deductible	$6,000 *
• Benefit Percentage	Deductible and 100%
The Deductible for the family plan is met by the first expenses incurred by covered members of the family. The family Deductible may be met entirely by charges incurred by one Covered Person, or by a combination of charges incurred by all family members.	
** A portion of The Plan Deductible is offset by amounts available through your company's Health Reimbursement Arrangement (HRA). Refer to the HRA Summary Plan Description for additional information.*	
SINGLE AND FAMILY COVERAGE PLANS	
Where the Plan specifies a Deductible, maximum dollar amount paid, or a maximum number of visits or hours allowed, benefits will apply toward each other in determining the maximums allowed under the Plan. Maximums are applied per Covered Person.	

5. Under Schedule of Benefits, the section titled Prescription Drugs has been deleted and replaced with the following:

Prescription Drugs
The Prescription Drug Card plan has a combined (retail and Mail Order) $250 Deductible per person per Calendar Year. The Prescription Drug Deductible does not apply to the medical Deductible or Out-of-Pocket Maximum. After the Deductible, if you use the Prescription Drug Card at a Participating Pharmacy, there will be a: • $10 Co-pay for up to a 34 day supply of Generic • $25 Co-pay for up to a 34 day supply of Name Brand with no Generic equivalent • $40 Co-pay for up to a 34-day supply of Name Brand with Generic equivalent After the Deductible, if you use the Mail Service program, there will be a • $20 Co-pay for up to a 90 day supply of Generic • $50 Co-pay for up to a 90 day supply of Name Brand with no Generic equivalent • $80 Co-pay for up to a 90-day supply of Name Brand with Generic equivalent No benefit is available if you do not use a Participating Pharmacy or the Mail Service program.

6. Under Covered Expenses, the section titled Chiropractic Care has been deleted and replaced with the following:

   Chiropractic Care - Services provided by a Chiropractor for Medically Necessary and maintenance care, subject to the limitations in the Schedule of Benefits.

7. Under Covered Expenses, the section titled Durable Medical Equipment has been deleted and replaced with the following:

   Durable Medical Equipment - The charges for the rental (but not to exceed the purchase price) of wheelchairs, oxygen equipment, hospital beds and other durable medical equipment prescribed by a Physician and required for therapeutic use in treatment of active Illness or injury, except that in the event the purchase price of the Durable Medical Equipment cannot be established because the equipment is generally not offered for purchase, rental charge will continue to be covered by the Plan. Covered Durable Equipment will include the purchase of a cardiac pacemaker.

   Coverage is provided for the purchase of equipment when the extended use of eligible rental equipment is deemed to be Medically Necessary by the Plan.

   Benefits are not provided for Durable Medical Equipment that is more elaborate or customized than the cost of the least expensive adequate equipment.

8. Under Covered Expenses, the section titled Morbid Obesity has been deleted and replaced with the following:

   Morbid Obesity - Physician and dietitian consultations and services, and physician or hospital directed programs to treat Morbid Obesity. Initial charges for treatment of Morbid Obesity, including prescription drug charges, must be submitted to the Contract Administrator along with a Physician's statement of medical necessity diagnosing Morbid Obesity. Prescription Drug charges must be submitted to the Contract Administrator and will be reimbursed to the Co-pay level listed in the Schedule of Benefits, Prescription Drugs. Coverage is limited to the Maximum Lifetime Benefit shown in the Schedule of Benefits. The Plan will not cover services for, or related to bariatrics surgery or charges for diet supplements.

9. Under Covered Expenses, the section titled Pre-natal Care has been added as follows:

   Pre-natal Care - Comprehensive care provided during pregnancy, prior to delivery, also including risk assessment, prenatal education, psychosocial support and use of specialized skills and technology as needed.

10. Under Coverage Continuation Option, the following has been added after the section titled Second qualifying event extension of 18-month period of continuation coverage:

    Rights under USERRA (The Uniformed Services Employment and Reemployment Rights Act)

    If you leave your job to perform military service you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.

11. Under Claims Procedures in the section titled Procedures for Filing Benefit Claims – Post-service Claim, bullet #3 has been deleted and replaced with the following:

    3. Written claims should be submitted as soon as possible after expenses are incurred to:

    Sheffield, Olson and McQueen, Inc.
    2145 Ford Parkway, Suite 300
    St. Paul, Minnesota 55116-1914

12. Under Your ERISA Rights, the first bullet in the section titled Receive Information about your Plan and Benefits has been deleted and replaced with the following:

Receive Information about Your Plan and Benefits

ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.

13. Under Your ERISA Rights, the section titled Assistance with your Questions has been deleted and replaced with the following:

Assistance with your Questions

If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquires, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

TABLE OF CONTENTS

GENERAL PLAN INFORMATION

Plan Sponsor:	Farmers Cooperative Association 1206 South Douglas Hwy Gillette, WY 82716 307-682-4468
Name of Plan:	Medical Benefit Plan of Farmers Cooperative Association
Group Number:	593
Plan Sponsor Tax ID Number:	83-0117270
Plan Number:	501
Effective Date:	February 1, 2000 Restated effective March 1, 2004
Plan Year End:	January 31
Type of Plan:	Medical Coverage
Contract Administrator:	Sheffield, Olson & McQueen, Inc. 2145 Ford Parkway, Suite 300 St. Paul, Minnesota 55116-1914 (651) 695-2500 or 1-800-486-7664
Agent for Service of Legal Process:	Farmers Cooperative Association 1206 South Douglas Hwy Gillette, WY 82716 307-682-4468
Contribution Basis:	This Plan provides non-contributory coverage for Employees and Dependents.

Purpose of Plan

The purpose of the Plan is to provide certain health care benefits for eligible Employees of the Employer and their eligible Dependents.

As a member of the Plan, your rights and benefits are determined by the provisions of the Plan. This booklet describes those rights and benefits. It outlines what you must do to be covered. It explains how to file claims. It is your explanation booklet while you are covered.

In addition to the limitations with respect to benefits set forth elsewhere in the Plan, nothing contained herein shall be construed as a guarantee of employment.

PLEASE NOTE: Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, pre-admission review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims, or lack of coverage. These provisions are explained in this document.

A Covered Person should contact the Contract Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test, or any other aspect of Plan benefits or requirements.

PLEASE READ YOUR BOOKLET CAREFULLY. We suggest that you start with a review of the terms listed in the **DEFINITIONS** section. Terms which have a special meaning begin with a capital letter and are explained in the **DEFINITIONS** section.

FUNDING - SOURCES AND USES

Method of Funding

Plan benefits are self-funded and are provided directly from the general assets of the Plan Sponsor. The Plan Sponsor is responsible for the financing and administration of the Plan. A third party administrator provides claims administration. The Plan is not insured.

The Employer may require that Covered Persons contribute toward the cost of providing Plan benefits. The amount of such contributions will be determined by the Employer and may be changed by the Employer from time to time. The Employer will deduct such contributions on a regular basis from the wages or salary of Employees who receive coverage under the Plan.

Plan Benefits

Contributions will be applied to provide the benefits for Covered Expenses under the Plan.

Administration Expenses

Contributions will also be used to pay administrative expenses of the Plan in accordance with the terms and conditions of the Contract Administrative Service Agreement signed by the Plan Sponsor and the Contract Administrator.

ADMINISTRATIVE PROVISIONS

Type of Plan

The Plan is a welfare plan to provide benefits for eligible health care expenses for covered Employees of the Employer and their Dependents.

Type of Administration

This Plan is administered by a Contract Administrator under the terms and conditions of a Contract Administrative Service Agreement between the Plan Sponsor and Contract Administrator.

Incontestability

No statement made by any Covered Person under this Plan relating to themselves or a minor Dependent shall be used in contesting the validity of the coverage with respect to which the statement was made, unless it is contained in a written application signed by the person or the guardian of such person if a minor. Absent fraud, coverage will not be contested after such coverage has been in force for a period of two years.

Legal Actions

No action at law or in equity shall be brought to recover on the Plan prior to the expiration of sixty (60) days after the written proof of loss has been furnished in accordance with the requirements of the Plan. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

Workers' Compensation Coverage

This Plan is not in lieu of and does not affect any coverage required by Workers' Compensation laws or similar laws.

Amendment, Termination and Administration of Plan

The Plan Sponsor reserves total rights and power to alter and amend or terminate the Plan, at any time within its discretion by adoption of a written amendment containing the new terms of the Plan. The Plan Sponsor has full discretion to determine eligibility of benefits and to construe Plan terms and conditions.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Expenses incurred before termination, amendment or elimination.

Independent Contractor Relationship

The relationship between the Employer, the Contract Administrator, any Preferred Provider Network, and any Preferred Providers are contractual relationships between independent contractors. The relationship between a Covered Person and any provider remains that of patient and health care provider. The provider is solely responsible for any health care provided to a Covered Person.

Conformity With Governing Law

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

PROVISION OF PROTECTED HEALTH INFORMATION TO PLAN SPONSOR

Introduction

With respect to this Plan, certain members of the Company's workforce have access to the individual identifiable health information of Plan participants for administrative functions of the Plan. When this health information is provided from the Plan to the Plan Sponsor, it is Protected Health Information (PHI).

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations (the "Privacy Rules") restrict the Plan Sponsor's ability to use and disclose PHI. The following HIPAA definition of PHI applies to this plan amendment:

> *Protected Health Information:* Protected health information means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present, or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased.

Effective April 14, 2004, the Plan Sponsor shall have access to PHI from the Plan only as permitted under this plan or as otherwise required or permitted by HIPAA and the Privacy Rules.

Permitted Disclosure of Enrollment/Disenrollment Information

The Plan may disclose to the Plan Sponsor information on whether the individual is participating in the Plan, or is enrolled in or has disenrolled from a coverage offered by the Plan.

Permitted Uses and Disclosures of Summary Health Information

The Plan may disclose Summary Health Information to the Plan Sponsor, provided the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (b) modifying, amending, or terminating the Plan.

"Summary Health Information" means: information that (a) summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a Health Plan; and (b) from which the information described at 42 CFR § 164.514(b)(2)(I)(B) has been deleted, except that the geographic information described in 42 CFR § 164.514(b)(2)(I)(B) need only be aggregated to the level of a five-digit zip code.

Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administrative Purposes

Unless otherwise permitted by law, and subject to the conditions of disclosure described below and subject to obtaining written certification pursuant to the conditions of disclosure, the Plan may disclose PHI to the Plan Sponsor, provided the Plan Sponsor uses or discloses such PHI only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Plan Sponsor on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor, and they do not include any employment-related functions.

Notwithstanding the provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR § 164.504(f).

Conditions of Disclosure for Plan Administration Purposes

Plan Sponsor agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Plan, Plan Sponsor shall:

a. Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law.
b. Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI.
c. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
d. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.
e. Make available PHI to comply with HIPAA's right to access in accordance with 45 CFR § 164.524.
f. Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526.
g. Make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528.
h. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements.
i. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
j. Ensure that the adequate separation between Plan and Plan Sponsor (i.e., the "firewall") required in 45 CFR § 164.504(f)(2)(iii), is satisfied.

Adequate Separation between Plan and Plan Sponsor

Plan Sponsor shall allow access to PHI to the Privacy Officer and individuals named by the Privacy Officer. No other persons shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use PHI to the extent necessary to perform the plan administration functions that the Plan Sponsor performs for the Plan. In the event that any of these specified employees do not comply with the provisions of this Section, that employee shall be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to the Plan Sponsor's employee discipline and termination procedures.

Certification of Plan Sponsor

The Plan shall disclose PHI to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR § 164.504(f)(2)(iii), and that the Plan Sponsor agrees to the conditions of disclosure set forth above.

YOUR ROLE IN CONTROLLING HEALTH CARE COSTS

Health care costs have risen dramatically over the past few years. Today if you are sick or injured, your medical bills may be very high. This is particularly true if you are hospitalized.

There are steps you can take personally to lower your medical costs:

- **PRACTICE GOOD HEALTH HABITS.** Eat a balanced diet, exercise regularly and get enough sleep. Learn how to handle stress. Stop smoking and avoid excessive use of alcohol. Staying healthy is the best way to control your medical costs.

- **SEE YOUR DOCTOR EARLY.** Don't let a minor problem become a major one. This makes treatment more difficult and expensive.

- **HAVE SURGERY PERFORMED ON A SAME DAY BASIS.** Many procedures can now be done safely without staying in the Hospital. You can have these surgeries performed on an Out-patient basis or at a place other than a Hospital and go home the same day.

- **HAVE X-RAY OR LABORATORY TESTS DONE AS AN OUT-PATIENT.** Out-patient pre-admission and diagnostic tests can save costly room and board charges.

- **COMPARE PRESCRIPTION DRUG PRICES.** Discuss the use of generic drugs with your doctor or pharmacist. Generic drugs are often cheaper than brand name drugs for the same quality.

- **CONSIDER SKILLED NURSING FACILITIES.** This service offers quality care in comfortable surroundings for less cost than staying in the Hospital.

- **DISCUSS FEES BEFORE TREATMENT.** Talk about the cost of treatment with your doctor.

- **REVIEW MEDICAL BILLS CAREFULLY.** Make sure you understand the charges and that you are billed only for the services you receive. Keep your medical records up-to-date.

Be sure to discuss all questions with your doctor. You may at times be reluctant to ask, but you should know why a proposed treatment is needed and how much it will cost. With today's health care costs, your doctor will understand your concern about your medical expenses.

DEFINITIONS

Accidental Bodily Injury - Any Accidental Bodily Injury caused by external forces under unexpected circumstances and which does not arise out of or in the course of the employment of a Covered Person. Sprains and strains will not be considered Accidental Bodily Injury for purposes of benefit determination.

Active Employment - With respect to any eligible Employee, active performance of all customary duties of the Employee's occupation, at the Employee's usual place of employment, for the Employer for not less than 30 hours per week, and not on a temporary basis.

An Employee shall be deemed in Active Employment on each day of a regular paid vacation, or a regular non-working day, provided the Employee was in Active Employment on the last preceding regular working day.

Ambulatory Surgical Center - Any public or private establishment with an organized medical staff of Physicians; with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; with continuous Physician services and registered professional nursing services whenever a patient is in the facility; and which does not provide services or other accommodations for patients to stay overnight.

Annual Enrollment Period - . The period designated by the Employer during which the Employee or dependent who did not enter the plan when first eligible may enter the Plan. Please see the section titled **Eligibility and Effective Date** for additional information.

Benefit Percentage - The percentage of a Covered Expense which the Plan pays (as shown in the Schedule of Benefits).

Birthing Center - Any licensed health facility, place, or institution which is not a Hospital, or in a Hospital, where births are planned to occur away from the mother's usual residence, following a normal uncomplicated pregnancy.

Calendar Year - The period beginning on January 1st and ending the following December 31st. When a person first becomes covered the first Calendar Year begins on the Effective Date of coverage.

Certified Nurse Midwife - A licensed registered nurse who has been certified by the American College of Nurse Midwives as a Nurse Midwife.

Co-insurance - The percentage of a Covered Expense which the Covered Person is responsible for paying.

Contract Administrator - The organization providing administrative services to the Employer in connection with the operation of the Plan and performing such other functions, including processing and payment of claims as may be delegated to it.

Convalescent Hospital - **(see Extended Care Facility)**

Co-pay or Co-payment - An amount a Covered Person must pay per service or visit, not attributable to Deductibles or Co-insurance.

Covered Expense - Any expense listed in the Covered Expenses section of this Plan, to the extent such expense is not excluded or otherwise limited by this Plan.

Covered Person - Any eligible Employee or eligible Dependent whose coverage became effective and has not terminated.

Creditable Coverage - Includes coverage under most group health plans, individual health insurance, Medicare, Medicaid, church plans, medical coverage provided by the government for uniformed services, medical coverage through the Indian Health Service or a tribal organization and state sponsored health insurance coverage or public health plan. Creditable coverage does not include liability, dental, vision, specified disease and/or other supplemental-type plans.

Custodial Care - Services (including room and board) or supplies provided to a person which consist primarily of basic care given to maintain life and/or comfort with no reasonable expectation of cure or improvement of the Illness and which can generally be provided by an individual without special training.

Deductible - An amount which each Covered Person must contribute toward payment of Covered Expenses as set forth in the Schedule of Benefits.

Dependent - A properly enrolled person who is an Employee's lawful spouse, an unmarried child under age 19; or an unmarried student age 19, but less than 25 if such child is primarily dependent upon the Employee for financial support and is in full-time school attendance at any accredited high school, trade school, college or university. Children include:

1) Natural or legally adopted children;

2) Step-children;

3) Other children if:

   a) you are a legal guardian of the child(ren), and
   b) you pay 100% of their support; and
   c) they live with you or are a student as described above.

Coverage can be continued beyond the limiting age for a dependent child who is incapable of self support because of a Developmental Disability or physical handicap. Application for continuing coverage must be made within thirty-one (31) days of the child attaining the limiting age. Coverage will continue as long as the child continues to be incapable of self sustaining employment and remains primarily dependent on you. The term "Dependent" does not include any Dependent who is on active duty in a military service, except for temporary active duty of thirty-one (31) days or less, or a child who is eligible for coverage under this Plan as an Employee.

Developmental Disability - A child's substantial Disability which results from mental retardation, cerebral palsy, epilepsy or other neurological disorder and is diagnosed by a Physician as a permanent or long term continuing condition.

Disability or Totally Disabled - With reference to an Employee, it is Disability resulting solely from an Illness which prevents an Employee from engaging in any employment or occupation for which he/she is or becomes qualified by reason of education, training, or experience and only when such Employee is, in fact, not engaged in any employment or occupation for wage or profit. For a Dependent, it is Disability which prevents a Dependent from engaging in substantially all the normal activities of a person in good health of like age and sex. A Covered Person must also be under the care of a Physician in order to be Totally Disabled for benefit purposes.

Durable Medical Equipment - Equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of Illness or injury, (d) is appropriate for use in the home, and (e) has been prescribed by a Physician.

Effective Date of the Plan - The date this Plan is effective with the Contract Administrator.

Emergency Admission - An Emergency Admission is hospitalization for a condition which, unless promptly treated, would put the patient's life in danger or cause serious damage to a bodily function of the patient.

Employee - A person employed by the Employer. The term Employee shall not include independent contractors or leased employees.

Employer - The Plan Sponsor as stated in the General Plan Information section of this Plan.

Enrollment Date - Means the first day of coverage under this Plan or, if there is a Waiting Period, the first day of the Waiting Period.

Extended Care Facility - An institution which is duly licensed as a Convalescent Hospital, Extended Care Facility, Skilled Nursing Facility, or Intermediate Care Facility and is operated in accordance with governing laws and regulations; is primarily engaged in providing accommodations and skilled nursing care 24 hours a day for convalescing persons, is under the full-time supervision of a Physician or a registered graduate nurse; admits patients only upon the recommendation of a Physician (other than the patient's own Physician), maintains complete medical records, and has available at all times the services of a Physician; has established methods and procedures for the dispensing and administering of drugs; has an effective utilization review plan; has a written transfer agreement in effect with one or more Hospitals; and is not, other than incidentally, a place of rest, for custodial care, for the aged, for drug addicts, for alcoholics, for the care of the mentally ill or persons with nervous disorders, for the care of senile persons, a nursing home, a hotel, a school or a similar institution.

Fiduciary - The person or organization that has the authority to control and manage the operation and administration of the Plan. The fiduciary has discretionary authority to determine eligibility for benefits or to construe the terms of the Plan. The named Fiduciary for this Plan is the Employer.

Home Health Care Agency - A Hospital, Home Health Care service organization or agency possessing a valid operating certificate issued in accordance with public health law authorizing such organization or agency to provide Home Health Care services.

Hospice Facility - An establishment which complies with all licensing, staffing, operating, and legal requirements in the state where it is located and, in any other state where it provides services, and is mainly engaged in providing palliative care for the terminally ill on a continuous 24-hour basis under the supervision of a duly licensed Physician or a registered nurse.

If the care is not supervised by a Physician, the Hospice Facility must have a duly licensed Physician available on a pre-arranged basis, maintain clinical records on all terminally ill individuals, and not be mainly be a place for the aged, a nursing or convalescent home, a custodial or a rest home.

A Hospice Facility may operate by itself, or as part of a Hospital, and must be located in the United States.

Palliative care means a course of treatment directed toward lessening or controlling pain. It makes no attempt to cure a terminal Illness or to prolong the life of a patient.

Hospital - An institution which is accredited as a Hospital under the Hospital Accreditation Program of the Joint Commission on the Accreditation of Hospitals; complies with all licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located; is primarily engaged in providing medical treatment to sick and injured persons as registered bed patients and maintains permanent facilities for five or more such patients; has a Physician in regular attendance 24 hours a day; continuously provides 24 hour a day nursing service by registered graduate nurses; maintains a daily medical record for each patient; maintains permanent facilities for major surgical operations on its premises; and, is not, other than incidentally, a place of rest, for custodial care, for the aged, for drug addicts or alcoholics, for the care of senile persons, a nursing home, a hotel, a school or similar institution.

An institution specializing in the care and treatment of psychiatric conditions, which would qualify as a Hospital, except that it lacks organized facilities on its premises for major Surgery shall nevertheless be deemed a Hospital.

For an emotionally handicapped dependent child, it also means a state licensed residential treatment center.

For treatment of alcoholism, drug addiction or chemical dependency, a residential treatment facility specializing in the care and treatment of alcoholism, drug addiction or chemical dependency will be considered a Hospital provided the facility is licensed as a treatment facility in the state in which it is operating.

A facility which is licensed and approved by the state in which it is operating as a rehabilitation facility whose primary purpose is to provide diagnosis, therapy, and restoration for persons who are disabled will be deemed a Hospital.

Hospital Average Semi-Private Charge - The standard charge by a Hospital for semi-private room and board accommodations, or the average of such charges where the Hospital has more than one established level of such charges, or the lowest charge by the Hospital for single bed room and board accommodations where the Hospital does not provide any semi-private accommodations.

Hospital Pre-certification - Approval by the Plan's designated Medical Management Services Program for a Hospital admission, which may include Pre-admission Review, Urgent Review, Concurrent Review and Retrospective Review.

Illness - An Illness shall be deemed to mean a bodily disorder, disease, mental infirmity or bodily injury. However, bodily injuries sustained in any one accident shall be considered one Illness, and all bodily disorders existing simultaneously which are due to the same or related causes shall be considered one Illness. Pregnancy is considered an Illness for the purposes of coverage under this Plan.

In-patient - A person physically occupying a Hospital room to which the person has been assigned on a 24 hour a day basis without being issued passes to leave the Hospital premises.

Intensive Care Area - A Hospital area or accommodation exclusively reserved for critically and seriously ill patients requiring constant observation as prescribed by the attending Physician, which provides room and board, specialized registered professional nursing and other nursing care and special equipment and supplies on a stand-by basis and which is separated from the rest of the Hospital's facilities.

Late Enrollee - An Employee or Dependent who enrolls for coverage after their initial Eligibility Date as described under Eligibility and Effective Dates. A Special Enrollee (see Definitions) shall not be considered a Late Enrollee.

Maximum Lifetime Benefit - Means the Maximum Lifetime Benefit payable during an individual's life while covered under the Plan. The Plan provides for a Maximum Lifetime Benefit for specific types of medical treatment (sub-maximums) as well as for total benefits provided by the Plan as indicated in the Schedule of Benefits. The Maximum Lifetime Benefit and sub-maximums, include any one or a combination of benefit Plan options provided by the Plan.

Medically Necessary - Services and supplies provided to a Covered Person which, in the judgment of the Plan Sponsor, (a) are appropriate and consistent with the diagnosis or treatment of the Illness, and (b) are customarily and reasonably recognized as appropriate throughout the Physician's profession, and (c) could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered, and (d) are not solely for the convenience of a Covered Person, Physician, Hospital or other provider.

For confinement in a Hospital, Medically Necessary also means that the treatment of the Illness could not have been provided in a Physician's office, in the Out-patient department of a Hospital, or in a lesser facility, without adversely affecting the patient's condition or the quality of medical care rendered. In regard to the type of accommodation, Medically Necessary shall mean that all semi-private or less expensive accommodations are occupied and the patient needs hospitalization immediately and such In-patient treatment cannot be deferred until less expensive accommodations become available or that the patient's condition requires him to be isolated for his own health or that of others.

Treatment that is Experimental/Investigational, or done primarily for research will not be considered as Medically Necessary.

Morbid Obesity - A condition in which the body weight is in excess of the norm for a person of the same age, sex and height by the lesser of one hundred (100) pounds or 40%.

Out-of-Pocket Maximum - Means the maximum amount of Deductible and Co-insurance a Covered Person and/or covered Dependents must pay for Covered Expenses during a Calendar Year before the Benefit Percentage increases to 100%.

Expenses incurred for the following will not be applied toward the Out-of-Pocket Maximum: (a) Co-pays; (b) any penalty amounts; (c) any charges defined under Limitations and Exclusions; and (d) Co-insurance for Out-patient Mental Health and Chemical Dependency treatment.

Out-patient - Hospital services rendered on other than an In-patient basis or services rendered at a covered non-Hospital facility.

Partial Hospitalization - Means continuous treatment for at least four hours, but not more than 12 hours, in any 24-consecutive-hour period in a Hospital.

One day of In-patient care reduces the available number of partial hospitalization days by two; two days of partial hospitalization reduces the available number of In-patient care days by one.

Physician - A person, other than the Covered Person or a Relative of the Covered Person, licensed to practice medicine or Surgery as a Doctor of Medicine, (M.D.) or as a Doctor of Osteopathy, (D.O.). Physician shall include a person licensed to practice as a Dentist (D.D.S. or D.M.D.), Podiatrist (D.P.M.), Chiropractor (D.C.), Optometrist (O.D.), Licensed Psychologist or Licensed Consulting Psychologist, Licensed Social Worker (or equivalent as defined by state statutes), or a Licensed Community Health Center or Clinic as defined by state statutes. Physician shall also include a registered graduate nurse (R.N.) who is licensed as certified to engage in advanced nursing practice as a nurse anesthetist, nurse midwife or nurse practitioner, acting within the scope of such license.

Plan - Plan or Employee Benefit Plan means the benefits the Plan Sponsor has agreed to provide for Covered Persons. The term Plan includes this Plan as well as any prior self-funded medical Plan maintained by the Plan Sponsor.

Plan Sponsor - The person/organization responsible for the day-to-day functions and management of the Plan. The Plan Sponsor may employ persons or firms to process claims and perform other Plan-connected services. The Plan Sponsor is the named plan administrator within the meaning of Section 414(g) of the Internal Revenue Code of 1986, as amended, and is the named Administrator within the meaning of Section 3(16)(A) of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Pre-existing Condition - A Pre-existing Condition is any condition, Illness or injury which is diagnosed or for which treatment is received or recommended prior to the Covered Person's Enrollment Date, subject to the Plan's Pre-existing Conditions Limitation. ***This Plan does not contain a Pre-existing Condition Limitation.***

Preferred Pharmacy(ies) - Participating stores and designated mail order providers according to the list provided by the Employer.

Preferred Provider Organization (PPO) - Hospitals, Physicians and medical service providers who have contracted with the Employer. A directory of Preferred Providers is available from the Plan Sponsor or Contract Administrator. Inquiries concerning a particular provider can also be directed to the Contract Administrator.

Professional Services - Services received from or under the direction of a Physician.

Relative - A spouse, or a parent, brother, sister, or child of the Covered Person.

Special Enrollment – See heading under the section titled **Eligibility and Effective Dates.**

Special Enrollee - An Employee or Dependent who is entitled to and requests Special Enrollment as described under Eligibility and Effective Dates: (a) within thirty-one (31) days of losing other Creditable Coverage; or (b) within thirty-one (31) days of marriage, birth, adoption, or placement for adoption.

Surgery - Is limited to the following procedures performed by a Physician: Cutting, Suturing, reduction of fracture, reduction of dislocation, electrocauterization, tapping (paracentesis), administration of artificial pneumothorax, removal of stone or foreign body by endoscopic means, debridement, or injection of sclerosing solution, or any other procedures commonly considered Surgery.

Urgent Care Facility - A facility or Hospital unit which is primarily engaged in providing minor emergency and episodic medical care to a Covered Person. A legally qualified Physician, a registered graduate nurse (R.N.) and a registered x-ray technician must be in attendance at all times that the clinic is open. The clinic's facilities must include x-ray and laboratory equipment and a life support system. For the purposes of this Plan, a facility meeting these requirements is considered an Urgent Care Facility, regardless of the name.

Usual and Customary - A charge made by a provider of service which does not exceed the general level of charges made by other providers of similar standing rendering or furnishing such services, medicines, or supplies within the area in which the charge is incurred, for an Illness or injury comparable in severity and nature to the Illness or injury being treated. The term "area" as it would apply to any particular service, medicine, or supply means a county or such greater area as is necessary to obtain a representative cross section of the level of charges. Usual and Customary shall not apply to Preferred Provider Organization discounted charges.

Waiting Period - Means the period of time that must pass under the Plan (or for purposes of determining Creditable Coverage, any other health plan) before an Employee or Dependent is eligible to enroll in the Plan. As an exception to the above with regard to determining Creditable Coverage, the time between the date a Late Enrollee or Special Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage shall not be treated as a Waiting Period.

ELIGIBILITY AND EFFECTIVE DATES

Enrollment

Enrollment shall be made on forms provided by the Plan Sponsor or Contract Administrator for such purpose. If Dependents are to be enrolled, Employees enrolled for family coverage must cover **all** eligible Dependents.

Employee - Eligibility Date

An Employee is eligible to enroll on the date he/she satisfies the Plan's Waiting Period of 90 days of Active Employment with the Employer. Coverage will be effective as provided below.

Employee - Effective Date

Eligible Employees who are in Active Employment on the Effective Date of the Plan and who were validly covered under the Employer's plan of coverage which this Plan replaces, will be covered on the Effective Date of the Plan. All other Employees will be effective as follows.

Employee's coverage is effective on the first of the month coincident with or following the Plan's Waiting Period of 90 days of Active Employment.

If Employee coverage is contributory and application is made, and received by the Plan Sponsor before, on or within thirty-one (31) days of completion of the Plan's Waiting Period, as shown above, coverage will be effective on the Effective Date.

Employee - Late Enrollee

If application is made and received by the Plan Sponsor after thirty-one (31) days beyond the initial Eligibility Date (other than during a Special Enrollment period available to Special Enrollees), the Employee shall be a Late Enrollee. A Late Enrollee may only enroll for coverage during the Plan's Annual Enrollment Period as designated by the Employer.

Dependents - Eligibility Date

Dependents of eligible Employees are eligible to be enrolled for coverage on the later of the following dates:

- The date the Employee is eligible;
- The date the individual meets the definition of a Dependent.

Dependents - Effective Date

Dependents may become covered only if the Employee makes written application for coverage for such Dependents in a form furnished by the Plan Sponsor or Contract Administrator for the purpose (see exception for Newborn/Adopted Children).

Dependent child(ren), of a covered Employee, named in a Qualified Medical Child Support Order (QMCSO) shall become covered under the Plan on the date the QMCSO specifies that coverage shall commence.

If Dependent coverage is contributory and application is made and received by the Plan Sponsor on, before or within thirty-one (31) days of the Eligibility Date, Dependent(s) coverage shall be effective on the same date the Employee becomes effective for coverage, or on the date the individual meets the definition of Dependent, whichever is later.

Dependent - Late Enrollee

If application is made and received by the Plan Sponsor after thirty-one (31) days beyond the initial Eligibility Date (other than during a Special Enrollment period available to Special Enrollees), the Dependent, of a Covered Employee, shall be a Late Enrollee. A Late Enrollee may only enroll for coverage during the Plan's Annual Enrollment Period as designated by the Employer.

Newborn/Adopted Children

A newborn baby will be covered from birth if the Employee has family coverage in effect for other family members at the time of birth. An adopted child will be covered from the date of placement if Employee has family coverage in effect on other family members at the time of placement. If family coverage is not in effect, newborn or adopted children must be enrolled within thirty-one (31) days of birth or placement in order for coverage under the Plan to become effective on the date of birth or placement. After thirty-one (31) days, the newborn or adopted child(ren) will be considered a Late Enrollee.

Special Enrollment Provision

If an eligible Employee or Dependent waives coverage under the Plan at the time of initial Eligibility (and states in writing at that time that coverage was waived because of alternative health coverage) but subsequently loses coverage under the other health plan and makes application for coverage under this Plan within thirty-one (31) days of the loss, such individual shall be a Special Enrollee provided such person: (a) was under a COBRA (Consolidated Omnibus Budget Reconciliation Act) continuation provision and the coverage under such provision was exhausted; or (b) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, or loss of Dependent status) or employer contributions toward such coverage were terminated. Individuals who lose other coverage due to nonpayment of premium or for cause (e.g., filing fraudulent claims) shall not be Special Enrollees hereunder.

An eligible Employee or Dependent who waives coverage under this Plan at the time of initial Eligibility and seeks to enroll in this Plan as a result of the acquisition of a new Dependent through marriage, birth, adoption or placement for adoption shall be a Special Enrollee hereunder if the eligible Employee or Dependent enrolls within thirty-one (31) days of the acquisition of the new Dependent.

Coverage for a Special Enrollee shall be effective: (a) in the event an Employee or Dependent waived coverage for the sole reason of the existence of alternative health coverage, and loses such coverage as described above, not later than the first day of the first calendar month following the date the completed request for enrollment is received by the Plan; or (b) in the event of marriage, the first day of the first calendar month following the date the completed request for enrollment is received by the Plan; or (c) in the event of birth, adoption or placement for adoption, the date of such birth, adoption or placement for adoption.

Annual Enrollment Period

Eligible Employees and their Dependents, who did not enroll for coverage when initially eligible, or during a Special Enrollment period, if applicable, will be considered a Late Enrollee. Late Enrollees may enroll for coverage under the Plan once a year during the Plan's Annual Enrollment Period, as designated by the Employer.

Qualified Medical Child Support Orders

Notwithstanding any other Plan provision, upon receipt of a Qualified Medical Child Support Order (QMCSO), the Plan will provide benefits in accordance with Section 609 of ERISA. The Plan Sponsor will establish written procedures for determining (and shall have sole discretion to determine) whether a QMCSO is qualified and for administering the provision of benefits under the Plan pursuant to a QMCSO. The Plan Sponsor may seek clarification and modification of the order, up to and including the right to seek a hearing before the court or agency which issued the order.

Uniformed Services Employment and Reemployment Rights Act

Notwithstanding any other Plan provision, this Plan will provide benefits in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994. With respect to any Employee or Dependent who loses coverage under the Plan during the Employee's absence from employment by reason of military service, no Pre-existing Condition Limitation or Waiting Period may be imposed upon reinstatement of such Employee's or Dependent's coverage upon reemployment of the Employee unless such Pre-existing Condition Limitation or Waiting Period would have otherwise applied to such Employee or Dependent had the Employee not been on military leave of absence.

Family and Medical Leave Act

All Plan provisions are intended to be in compliance with the Family and Medical Leave Act of 1993 (FMLA). To the extent the FMLA applies to the Employer, group health benefits may be maintained during certain leaves of absence at the level and under the conditions that would have been present as if employment had not been interrupted. Employee eligibility requirements, the obligations of the Employer and Employee concerning conditions of leave, and notification and reporting requirements are specified in the FMLA.

Reinstatement of Coverage

An Employee's coverage that has terminated due to termination of employment, lay-off, reduction to part-time status, or Employer approved leave of absence, may be reinstated under the following condition:

(a) The Employee returns to full-time Active Employment within six (6) months of the date such termination or leave commenced; and

(b) The Employee re-enrolls for coverage within thirty-one (31) days of the return date to such Active Employment.

The reinstated coverage will be effective on the date the Employee returns to Active Employment. **"Reinstatement"** means that any previous benefit limitations, maximums or waiting periods applied prior to such termination or leave, will be recognized under the reinstated coverage. In other words, coverage will continue as if no time has elapsed between the termination of coverage and reinstatement.

Change in PPO Designation

If more than one plan of coverage is offered by the Employer, covered Employees will have the opportunity to change their Plan election once a year during the Plan's annual enrollment period as designated by the Employer. The Plan's Pre-existing Conditions Limitation and any previous benefit limitations, maximums or waiting periods previously applied or satisfied will be recognized for currently covered individuals.

Dual Coverage

When a husband and wife are both benefit eligible Employees with this Employer, both husband and wife may elect single coverage through this Plan, or one may elect to be covered as a Dependent of the other, but may not also elect single coverage. When a husband and wife are both enrolled for coverage as Employees under this Plan, dependent children can be covered under either Employee's coverage, but not both.

If a husband and wife are both Employees and are covered as Employees under this Plan and one of them terminates, the terminating spouse and any of his/her covered Dependents will be permitted to immediately enroll under the remaining Employee's coverage, provided written application is made and received within thirty-one (31) days of the spouse's loss of coverage. Such coverage shall be deemed a continuation of prior coverage and any previous benefit limitations, maximums, or waiting periods applied prior to the change in enrollment will be recognized under the replacement coverage.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions (Pre-existing Conditions) present before your Enrollment Date under this Plan. The period during which the Pre-existing Conditions Limitation applies will be reduced by the length of time during which you and your eligible Dependents were covered under other Creditable Coverage, provided there has been no break in such coverage which exceeds 63 days (excluding Waiting Periods or HMO affiliation periods).

Creditable Coverage includes coverage under most group health plans, individual health insurance, Medicare, Medicaid, church plans, medical coverage provided by the government for uniformed services, medical coverage through the Indian Health Service or a tribal organization and state sponsored health insurance coverage or public health plan. Creditable coverage does not include liability, dental, vision, specified disease and/or other supplemental-type plans.

This information is included in this document for reporting purposes. This Plan does not contain a Pre-existing Conditions Limitation.

CERTIFICATION OF CREDITABLE COVERAGE

In general, a group health plan and each health insurance issuer offering group health insurance coverage under a group health plan, is required to furnish Certificates of Creditable Coverage in accordance with the requirements of HIPAA. A Certificate must be provided within a reasonable period of time upon the occurrence of any of the following events:

- A covered individual would lose coverage under the plan in the absence of COBRA continuation coverage; or
- In the case of an individual who has elected COBRA continuation, at the time COBRA continuation ceases; or
- In the case of an individual who is not entitled to COBRA continuation, at the time the individual's coverage under the plan ceases; or
- Upon the request of a previously covered individual provided the request is made within 24 months after coverage ceases.

If the prior plan or insurer does not provide a Certificate of Creditable Coverage, Creditable Coverage and Waiting Period information may be established through alternative means. The Plan will assist in obtaining a Certificate from any prior plan or issuer, if necessary. The individual shall cooperate with the Plan's efforts to verify coverage. The Plan may refuse to credit coverage where the individual fails to cooperate with the Plan's efforts to verify coverage.

A Certificate of Coverage should be provided to the Plan at the time you are enrolled for coverage. Upon receipt of a Certificate of Coverage, the Plan will make a determination as to the individual's Creditable Coverage and notify the individual of the determination. If the Plan determines that an individual is not subject to the Pre-existing Conditions Limitation, a notification will not be sent.

This information is included in this document for reporting purposes. This Plan does not contain a Pre-existing Conditions Limitation.

MEDICAL COVERAGE

MEDICAL MANAGEMENT SERVICES

Medical Management Program

The Plan requires that any In-patient Hospital admission be approved in order for you to receive the maximum allowed benefits. The Plan's Medical Management Services Program provider will review the admission and establish the number of In-patient days that are considered Medically Necessary for care and treatment. The Plan requires the following:

- If you are able to plan a Hospital confinement in advance you must call for ***Pre-admission Review***.
- If you are confined unexpectedly you must call for ***Urgent Review***.

If neither of these reviews is requested, the Medical Management Services Program may conduct a ***Retroactive Review*** when the bill is received.

The Plan does not cover:

- charges for Hospital room and board and other services and supplies that are furnished by the Hospital on days that were not Medically Necessary, or
- charges for Hospital room and board alone on days for which In-patient confinement was not Medically Necessary.

For the purposes of the Medical Management Services section, you means the Covered Person.

Penalty for Not Calling

If you do not call for a review of a Hospital confinement within the time limits shown below for Pre-admission Review or Urgent Review, benefit payment will be reduced by $1,000 for the confinement.

The $1,000 penalty does not apply towards any Deductible, Co-pay or Out-of-Pocket Maximum.

The Plan reserves the right to waive the penalty if the patient or his or her representative was unable to call due to incapacity, as determined by the Plan.

Exception For Childbirth Admissions

Pre-admission Review is not required on the first 48 hours of In-patient admission for normal delivery, or the first 96 hours of In-patient admission for cesarean delivery. Longer In-patient stays should be reviewed and approved for Medical Necessity. Ask your Physician or facility to call the Medical Management Program for a Concurrent Review within 48 hours, or the next working day following continuation of In-patient confinement. Charges incurred during In-patient stays in excess of the above limits, for Hospital room and board and other services and supplies, that are not considered to be Medically Necessary are not covered under the Plan.

Pre-certification does not Guarantee Benefit Payment

Pre-certification does not verify eligibility for benefits or guarantee benefit payment under the Plan. Any questions regarding benefits or eligibility should be directed to the Contract Administrator. Refer to your identification card for the name and number to call.

Pre-admission Review – Scheduled Hospital Admission

Pre-admission Review is an evaluation of a ***scheduled*** Hospital admission that is made by the Medical Management Services Program prior to a Hospital confinement.

- **The call must be made as soon as the Hospital confinement is scheduled. The penalty will apply if you do not call at least seven (7) days before the admission. The number to call is printed on your medical ID card.**
- The Medical Management Services Program will provide notification of the decision.
- A Pre-admission Review is valid for 90 days from the date of the scheduled admission.
- A request for Pre-admission Review is considered a Pre-service Claim.

Please note: Pre-admission Review may also be referred to as Prospective Review, Pre-service Review or Certification of Hospital confinement.

Urgent Review – Unscheduled Hospital Admission

An Urgent Review is an evaluation of an unscheduled Hospital admission that is made by the Medical Management Services Program due to an admission for an urgent condition.

An urgent condition is a condition for which a delay in treatment could seriously jeopardize your life or health or your ability to regain maximum function; or, for which, in the opinion of a Physician with knowledge of your medical condition, a delay in treatment would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

When you are admitted to the Hospital on an urgent basis you must call the Medical Management Services Program within 48 hours after start of the confinement or on the next business day, (whichever is later). The number to call is printed on your medical ID card.

- The Medical Management Services Program will provide the Urgent Review on the telephone at the time of the call.
- The Medical Management Services Program will provide notification of the decision.
- If you cannot give notice to the Medical Management Services Program yourself, one of the following must give such notice: your attending Physician, a member of your family, the admitting Hospital, or your representative.
- A request for an Urgent Review is considered an Urgent Care Claim.*

Concurrent Care Review

Concurrent Review is an evaluation that is made by the Medical Management Services Program to review the Medical Necessity of a Covered Person's confinement beyond the number of days that were allowed under the Pre-admission or Urgent Review.

- A Hospital confinement will be continuously reviewed by the Medical Management Services Program until the patient is discharged.
- The Medical Management Services Program will provide notification of extensions to the approved days as they occur.
- In-patient days that are not certified as being Medically Necessary and Room and Board charges for days for which In-patient confinement is not certified as being Medically Necessary are not covered.
- A Concurrent Care Review is treated as a Concurrent Review.

Retrospective Review

A Retrospective Review is an evaluation that is made by the Medical Management Services Program to review a confinement for which there was no Pre-admission or Urgent Review.

- The $1,000 penalty per confinement will apply if a Pre-admission or Urgent Review was not obtained according to the rules elsewhere in this section.
- The Medical Management Services Program will provide notification of the decision.
- In-patient days that are not certified as being Medically Necessary and Room and Board charges for days for which In-patient confinement is not certified as being Medically Necessary are not covered.
- A Retrospective Review is treated as an Urgent Care Claim.

SCHEDULE OF BENEFITS

BENEFIT MAXIMUMS & DEDUCTIBLE

BENEFIT MAXIMUMS

The Maximum Lifetime Benefit shown below is the overall maximum benefit available to any Covered Person while covered under the Plan. Lesser maximums may apply to specific conditions, levels of care or types of service, and are as specified.

Where the Plan specifies a maximum dollar amount paid, or a maximum number of visits or hours allowed, benefits paid for services incurred through the Preferred Provider Network and those incurred through a Non-Network Provider will apply towards each other in determining the maximum allowed under the Plan.

Maximum Lifetime Benefit $2,000,000

Maximum Lifetime Benefit limit for Chemical Dependency $25,000

Maximum Lifetime Benefit for Morbid Obesity $3,000

DEDUCTIBLE(S)

All Covered Expenses incurred with hospitals, physicians and medical services providers are subject to the Deductible, unless otherwise specified in the Schedule of Benefits.

Schedule of Benefits	
Benefit	**Payment**
SINGLE COVERAGE PLAN • Calendar Year Deductible • Benefit Percentage	 $2,500 * Deductible and 100%
FAMILY COVERAGE PLAN • Calendar Year Deductible • Benefit Percentage & Out-of-Pocket Maximum	 $5,000 * Deductible and 100%
The Deductible for the family plan is met by the first expenses incurred by covered members of the family. The family Deductible may be met entirely by charges incurred by one Covered Person, or by a combination of charges incurred by all family members.	
** A portion of The Plan Deductible is offset by amounts available through your company's Health Reimbursement Arrangement (HRA). Refer to the HRA Summary Plan Description for additional information.*	
SINGLE AND FAMILY COVERAGE PLANS	
Where the Plan specifies a Deductible, maximum dollar amount paid, or a maximum number of visits or hours allowed, Preferred Provider Network benefits and Non-Network benefits will apply toward each other in determining the maximums allowed under the Plan. Maximums are applied per Covered Person.	
Office Visits and Urgent Care	Deductible & 100%
Routine Care • Physicals, pre-cancer screening, immunizations, routine labs, routine hearing exams, routine vision exams	First $150 per Calendar Year at 100%, then Deductible & 100%
Well Child Care	First $150 per Calendar Year at 100%, then Deductible & 100%
Pre-natal Care	First $200 per Calendar Year at 100%, then Deductible & 100%
Chiropractic Care	Deductible & 100%, $750 per Calendar Year
Hospital and Professional Services *Pre-certification required for all In-patient Hospital confinements – $1,000 penalty if not pre-certified.*	
• In-patient • Out-patient • Emergency Room	Deductible & 100% Deductible & 100% Deductible & 100%
Mental Health and Chemical Dependency *Pre-certification required for all In-patient Hospital confinements - $1,000 penalty if not pre-certified.* *The Maximum Lifetime Benefit for Chemical Dependency is $25,000*	
• In-patient/Partial Hospitalization • Out-patient	Deductible & 100%, 10 days per Calendar Year Deductible & 100%, 15 visits per Calendar Year
Therapies: Physical, Occupational, Speech, Radiation & Chemotherapy	Deductible & 100%
Extended Care Facility	Deductible & 100%, 90 days per Calendar Year

Schedule of Benefits

Benefit	
Home Health Care - Must commence or be ordered within seven (7) days following a covered In-patient Hospital confinement	Deductible & 100%, 100 visits per Calendar Year
Hospice Care	Deductible & 100%
Ambulance	Deductible & 100%
Durable Medical Equipment/ Prosthetic Devices/Other	Deductible & 100%

Prescription Drugs

If you use the Prescription Drug Card at a Participating Pharmacy, there will be a:

- $10 Co-pay for up to a 34 day supply of Generic
- $25 Co-pay for up to a 34 day supply of Name Brand with no Generic equivalent
- $40 Co-pay for up to a 34-day supply of Name Brand with Generic equivalent

If you use the Mail Service program, there will be a

- $20 Co-pay for up to a 90 day supply of Generic
- $50 Co-pay for up to a 90 day supply of Name Brand with no Generic equivalent
- $80 Co-pay for up to a 90-day supply of Name Brand with Generic equivalent

No benefit is available if you do not use a Participating Pharmacy or the Mail Service program.

COVERED EXPENSES

Except as otherwise noted below or in the **Schedule of Benefits**, Covered Expenses are the Usual and Customary charges for the services listed, incurred by a Covered Person, subject to the Plan's **Definitions** and **Limitations and Exclusions** and all other provisions of the Plan. Service must be approved by a Physician and must be determined to be Medically Necessary by the Plan Sponsor or the party it delegates to conduct this review for the care and treatment of a covered Illness.

Alcoholism - See Chemical Dependency below.

Ambulance - Commercial ground or emergency air ambulance transportation to the nearest Hospital where care and treatment of the Illness or injury can be given or from the first Hospital where treatment is given to another Hospital in the area if necessary treatment is not available at the first Hospital, but no other expenses in connection with travel are included.

Anesthesia - Anesthesia and the charges made by a Physician for the administration of anesthesia.

Birth Control - Birth control pills or devices prescribed by a Physician, including injectable and implantable drugs and devices. For devices that are implantable, this benefit includes the associated Physician charges for insertion and removal. Coverage for implantable drug delivery devices is limited to one device every three years.

Blood and Blood Derivatives - The charges for blood, blood plasma, and other blood products if not replaced by or for the Covered Person, including charges incurred for self-donation of blood for anticipated surgery.

Chemical Dependency - Services provided by a Physician to diagnose and treat Chemical Dependency. Chemical Dependency does not include nicotine addiction, gambling addition or caffeine addiction. Please see special benefit maximums and Co-insurance allowance in the Schedule of Benefits.

Chemotherapy

Chiropractic Care - Services provided by a Chiropractor, subject to the limitations in the Schedule of Benefits.

Diabetic Supplies/Insulin - Charges for insulin when it is dispensed by a licensed pharmacist, and insulin syringes, needles, glucose, and ketone test strips, lancets and lancet devices. One Co-pay per vial, or 34-day supply, whichever is greater, when dispensed by a Preferred Pharmacy, or up to a 90-day supply for one Co-pay when purchased through the Mail Service Prescription Drug Program.

Diagnostic Services - Diagnostic laboratory and x-rays including services of a radiologist or pathologist.

Drug or Substance Abuse - **(see Chemical Dependency)**

Durable Medical Equipment - The charges for the rental (but not to exceed the purchase price) of wheelchairs, oxygen equipment, hospital beds and other durable medical equipment prescribed by a Physician and required for therapeutic use in treatment of active Illness or injury. Covered Durable Equipment will include the purchase of a cardiac pacemaker.

Coverage is provide for the purchase of equipment when the extended use of eligible rental equipment is deemed to be Medically Necessary by the Plan.

Benefits are not provided for Durable Medical Equipment that is more elaborate or customized than the cost of the least expensive adequate equipment.

Extended Care Facility - Charges made by an Extended Care Facility subject to the Limitations in the Schedule of Benefits.

Confinement must be preceded by confinement of at least three (3) days in a Hospital; be for the same condition causing the preceding confinement; commence within fourteen (14) days of discharge from such prior confinement; be one during which a Physician consults with the Covered Person at least once each seven (7) days. The fourteen (14) day period may be extended with prior approval from the Plan Sponsor.

Foot Care - Medically Necessary foot care, including devices such as custom molded orthotics, and orthopedic shoes which are part of a brace or custom molded foot support, limited to one per Calendar Year.

Hair Prosthesis - Hair prosthesis necessary due to the disease alopecia areata, radiation therapy or chemotherapy, limited to one prosthesis per Calendar Year, not to exceed $350.

Home Health Care - Home Health Care services and supplies furnished to a Covered Person in such person's home according to the following provisions:

- Must commence or be ordered within seven (7) days following Hospital confinement for which benefits are payable under this Plan and be for the same or related cause for which the Covered Person was confined; or, be in lieu of Hospital confinement.

- Part-time or intermittent nursing care is provided by a Home Health Care Agency, or a registered professional nurse (RN), or Home Health Care aide practicing under the supervision of a Home Health Care Agency, providing services which consist primarily of caring for the Covered Person, providing physical therapy, or speech therapy.

Each visit by a member of a Home Health Care team will be considered as one (1) visit, and four (4) hours of Home Health Care aide services will be considered as one visit.

Home Health Care does not include expenses for services of a person who ordinarily resides in the home of the Covered Person or is a member of your family, your spouse's family, or your Dependent; expenses for services rendered for any period during which you were not under the continuing care of a Physician; or expenses for custodial care and transportation services.

Home Infusion Therapy - When ordered by a Physician, the following services are covered when Medically Necessary:

- Solutions and pharmaceutical additives,
- Pharmacy compounding and dispensing services,
- Durable medical equipment,
- Ancillary medical supplies,
- Nursing services to train patient or another care giver, to monitor the home infusion therapy and emergency care,
- Other eligible Home Health Care services, as defined by the Plan, and supplies provided during the course of home infusion therapy.

Hospice Care - Charges made by a Hospice Facility for a Covered Person who is terminally ill; and has a medical prognosis of six (6) months or less to live; and the more appropriate treatment is palliative rather than curative; and the attending Physician recommends Hospice care.

Hospice care includes the Usual and Customary charges of a Hospice Facility for palliative care, services and supplies for the palliative management of a terminal Illness, and pre-death and bereavement counseling for you and your covered Dependents during the terminal Illness and until six (6) months after the death. Services and supplies received when confined at home, or on an Out-patient basis at a Hospice Facility while residing at home; or when confined as an In-patient at a Hospice Facility.

Hospice care does not include services and supplies provided by volunteers or persons who regularly do not charge for their services, pre-death counseling and bereavement counseling which is not provided through the hospice program of care, funeral services and arrangements; legal or financial services or counseling, or curative treatment or services.

Hospital Room and Board - The charges made by a Hospital, while the Covered Person is a registered In-patient, for daily room and board, but not to exceed the average semi-private charge at the Hospital of confinement.

Hospital Ancillary Services (Other Hospital Services) - The charges made by a Hospital, for services and supplies while the Covered Person is a registered In-patient or on an Out-patient basis.

Hospital Intensive Care Area - Charges made by a Hospital for an intensive care area, including, but not limited to, coronary care units.

Mammography - The Plan will pay for routine mammography as shown in the Schedule of Benefits (routine cancer screening). Diagnostic mammography is covered as any other X-ray procedure.

Mastectomy (Women's Health and Cancer Rights Act of 1998) - Hospital and Physician charges for Mastectomy, including charges for: 1) reconstruction of the breast on which the Mastectomy has been performed; 2) Surgery and reconstruction of the other breast to produce symmetrical appearance; and 3) coverage for Prostheses and physical complications of all stages of Mastectomy, including lymphedema; in a manner determined in consultation with the attending Physician and the Covered Person.

Medical and Surgical Supplies - Including, but not limited to, braces, crutches, casts, catheter kits, dressings, splints, trusses and surgical stockings and other Medically Necessary supplies ordered by a Physician.

Mental and Nervous Conditions - Services provided by a Physician to diagnose and treat Mental and Nervous Conditions are covered subject to the special limitations and Co-insurance in the Schedule of Benefits.

Family therapy is covered for a covered Dependent child with or without the presence of the patient. For any other Covered Person, family therapy is covered only if the patient is present. For group therapy, two sessions equal one treatment hour.

Morbid Obesity - Physician and dietitian consultations and services, and physician or hospital directed programs to treat Morbid Obesity. Initial charges for treatment of Morbid Obesity, including prescription drug charges, must be submitted to the Contract Administrator along with a Physician's statement of medical necessity diagnosing Morbid Obesity. Prescription Drug charges must be submitted to the Contract Administrator and will be paid as drugs which are purchased at a non-participating pharmacy. Coverage is limited to the Benefit Maximum shown in the Schedule of Benefits. The Plan will not cover services for, or related to bariatrics surgery or charges for diet supplements.

Nursing - The charges made by a registered graduate nurse (R.N.) for private duty nursing and prescribed in writing by the attending Physician specifically as to type and duration. However, upon written certification by Physician that private duty nursing services are Medically Necessary and the services of a registered graduate nurse are not available, charges made by a licensed vocational nurse (L.V.N.) or licensed practical nurse (L.P.N.) shall be a recognized Covered Expense.

Occupational Therapy - Medically Necessary occupational therapy rendered by a duly qualified occupational therapist, which is designed and adapted to promote the restoration of useful physical function lost due to Illness or injury, and which is not for recreational or social interaction or for maintenance or custodial care.

Oxygen - Oxygen and services and/or supplies for the administration of oxygen.

Pap Tests - The Plan will pay for routine Pap smears (routine cancer screening) as shown in the Schedule of Benefits.

Phenylketonuria - Special dietary treatment for phenylketonuria.

Physical Therapy - The charges for the professional services of a licensed Physical Therapist when specifically prescribed by a Physician as to type and duration, but only to the extent that the therapy is for improvement of bodily function.

Physician Services - The charges made by a Physician for medical and surgical treatment.

Covered Expenses for surgical services will be subject to the Usual and Customary charge. However, if more than one procedure is performed during the same operative session and through the same incision, only the most complex procedure performed by the Surgeon will be allowed up to the Usual and Customary charge. Each other procedure performed will be allowed up to 50% of the Usual and Customary charge.

Pregnancy - Pregnancy expenses will be covered to the same extent as an Illness, including elective or induced termination of pregnancy.

A newborn is considered to be a separate individual and must be enrolled for coverage, as specified under "Eligibility and Effective Dates", in order for coverage to apply. Hospital and Physician charges for a covered newborn are considered independent of the mother's charges and will be covered on the same basis as any other Covered Expense.

Coverage for one (1) home visit by a registered nurse is covered if the duration of the In-patient care is less than the time specified below. Services provided by the registered nurse include, but are not limited to parent education, assistance and training in breast and bottle feeding, the conducting any necessary and appropriate clinical tests. The home visit must be conducted within four (4) days following the discharge of the mother and child.

Newborns' And Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Prescription Drugs - The charges for drugs, medicines and injections lawfully obtainable only upon the written prescription of a Physician. Prescriptions written by a Dentist are included only for the purposes of controlling pain or infection. Prescription drugs are covered as shown in the Schedule of Benefits.

Prosthesis - The charges for initial artificial limbs or eyes required to replace natural limbs or eyes and charges for the adjustment, repair or replacement of existing prosthetic devices which the Plan determines to be Medically Necessary. Coverage is included for prosthetic devices incident to a Medically Necessary mastectomy including up to two (2) prosthetic bras per Calendar Year, or a penile prosthesis for the corrections of sexual dysfunction resulting from Illness or Surgery (see Mastectomy under Covered Expenses).

Provider Taxes - The Provider Taxes required to be paid under state or federal law, which is not preempted by ERISA, will be considered a Covered Expense under this Plan.

Radiation Therapy - Radium, radioactive isotope therapy and x-ray therapy.

Respiratory Therapy - Respiratory therapy rendered by a qualified respiratory therapist.

Routine Care - Routine exams, routine hearing exams, routine vision exams, physicals, immunizations, or laboratory procedures ordered by a Physician, subject to the limitations in the Schedule of Benefits.

Speech Therapy - Expenses for restorative or rehabilitative speech therapy necessary because of loss or impairment due to an Illness (not a functional nervous disorder) or Surgery on account of such Illness, or due to surgery to correct a congenital anomaly.

Sterilization - Tubal ligations or vasectomy

Temporomandibular Joint Disorder (TMJ) - Charges for orthognathic Surgery which corrects jaw and oral relations, including orthognathic splints to reposition the jaw.

Transplants - Covered Expenses will be subject to any applicable Deductible, Co-pay, Co-insurance, Out-of-Pocket Maximum and Maximum Lifetime Benefit of this Plan. Charges for confinement, treatment, service, or materials for the following human to human organ transplants:

- Bone Marrow transplants (or transfer)
- Stem Cell
- Heart
- Lung
- Heart/Lung
- Liver
- Kidney
- Pancreas
- Kidney/Pancreas
- Cornea
- Skin

The Plan also provides a separate elective program for transplants. Please refer to Alternative Benefits for Human Organ Transplants.

Donor Coverage for Transplants - The Plan covers eligible transplant donor expenses according to the following rules:

- When both the transplant recipient and the live donor are covered by this Plan, the Plan covers each patient under his or her respective coverage.

- When the transplant recipient is covered under this Plan, but the live donor is not covered by the Plan, the Plan covers both.

- When the transplant recipient is not covered under this Plan, but the donor is, the Plan does not cover either patient.

Well Child Care - Pediatric preventive services, appropriate immunizations, developmental assessments and related laboratory services to the limits shown in the Schedule of Benefits.

ALTERNATIVE BENEFITS FOR HUMAN ORGAN TRANSPLANTS

Coverage by the Plan for Alternative Benefits for Human Organ Transplants is provided under this program. If you do not choose this alternative benefit coverage, benefits for a human organ transplant will be payable as specified in the Plan's Schedule of Benefits and subject to all terms of the Plan.

DEFINITIONS

For the purpose of this coverage, the following terms have these meanings:

Eligible Transplant under this program

- Bone Marrow transplants (or transfer)
- Stem Cell
- Heart
- Lung
- Heart/Lung
- Liver
- Kidney
- Pancreas
- Kidney/Pancreas

Health Care Services - Medical care and supplies provided to or on behalf of you by a Transplant Network Hospital for your treatment plan for an Eligible Transplant. Services will include In-patient and Out-patient care, Organ Procurement, testing and donor identification, transportation and preparation of the human organ, Physician services, nursing services, anesthesiology and all ancillary health care services.

Organ or Bone Marrow Procurement - Removal, preservation and transportation of the donated organ or bone marrow.

Retransplantation Services - In-patient care for a retransplantation of the same organ/tissue type performed within one year of the date of the initial transplant procedure.

Specified Transplant - Any human to human organ or tissue transplant which is: (a) listed above under Eligible Transplant; and (b) a covered transplant at the chosen Transplant Network Hospital. A list of covered transplants at each Hospital may be obtained from the Contract Administrator.

Transplant Benefit Period - A continuous period of 370 days beginning five (5) days prior to the transplant procedure and ending 365 days after the transplant procedure. For purposes of determining Transplant Benefit Period, retransplants occurring within ten (10) days after discharge from the initial transplant will be treated as if it were the initial transplant.

Transplant Network Hospital - A Hospital participating in the Transplant Network program at the time of admission for the transplant. A current list of Transplant Network Hospitals may be obtained from the Contract Administrator.

Travel Companion - The person who accompanies you to and from a Transplant Network Hospital. The Travel Companion may accompany the patient for all or a portion of the transplant plan. In the event you are incapable of choosing a Travel Companion, the selection may be made by your legal guardian.

BENEFITS

This program provides benefits for a Medically Necessary human organ transplant subject to the Maximum Lifetime Benefit under the Plan.

For benefits to be payable under the alternative benefits program, the Covered Person must voluntarily choose to receive treatment through the alternative benefit transplant program, satisfy eligibility requirements and be considered to be a potential candidate for a human organ transplant by a Transplant Network Hospital.

DEDUCTIBLE AND PERCENTAGE PAYABLE

Benefits for Specified Transplant Covered Expenses, provided under this alternative benefits transplant program, are not subject to any applicable Deductible, Co-pay, Co-insurance or Out-of-Pocket Maximum of the Plan. The Plan's Maximum Lifetime Benefit will apply.

SPECIFIED TRANSPLANT COVERED EXPENSES

Specified Transplant Covered Expenses include the following, provided: (a) the transplant is incurred while covered for this benefit; (b) the expense is incurred at a Transplant Network Hospital; and (c) the expense is incurred during a Transplant Benefit Period.

1. Hospital and Professional Services for assessment/evaluation and transplant related care prior to transplantation.
2. Organ, Bone Marrow or Stem Cell Procurement.
3. Transplantation services for a Specified Transplant.
4. Retransplantation Services.
5. Hospital and professional charges for services rendered after discharge from the Hospital.

TRAVEL BENEFIT

The Plan will pay associated travel expenses related to a Specified Transplant when the Covered Person receiving the transplant resides more than fifty (50) miles from the transplant site. This includes:

1. Commercial transportation to and from the site of the transplant for the Covered Person receiving the transplant and one (1) Travel Companion; and
2. Reasonable and customary lodging and meal costs incurred by the Covered Person and one (1) Travel Companion. Reasonable and customary lodging and meal costs are limited to $250 per day for the Covered Person and one (1) Travel Companion.

Transportation, lodging and meal costs are limited to an aggregate maximum of $5,000 per Transplant Benefit Period for the Covered Person and one (1) Travel Companion. Although this travel benefit does not affect the Maximum Lifetime Benefit under the Plan, benefits may be taxable income to the Covered Person. Please consult your tax advisor.

Payment for associated travel expenses does not apply toward the Maximum Lifetime Benefit under the Plan.

GENERAL PROVISIONS

Responsibility: The Plan is not responsible for any Covered Person's decision to receive treatment, services or supplies from a Transplant Network Hospital nor does the Plan make warrants or representations for the qualifications of providers or treatment, services or supplies provided by a Transplant Network Hospital.

In order for an Eligible Transplant to be covered under the Alternative Benefits for Human Organ Transplants program, the Specified Transplant must be pre-certified.

EXCLUDED EXPENSES

This coverage is subject to the general medical exclusions shown in this Plan Document. Alternative Benefits for Human Organ Transplants Covered Expenses also exclude the following:

1. Charges for a transplant not listed under Eligible Transplant.
2. Charges incurred prior to the Transplant Benefit Period.
3. Charges incurred for testing administered to people other than the living donor. Charges incurred for testing administered to the donor if the donor has his or her own coverage.
4. Charges for any treatment, supply or device which is found by the Contract Administrator to be experimental, investigational or not a generally accepted medical practice.
5. Charges for a transplant of animal tissue to a human recipient.
6. Charges for mechanical devices designed to replace human organs. Use of a mechanical heart to keep a patient alive until a human donor heart becomes available or a kidney dialysis machine is a Covered Expense.
7. Charges incurred for keeping a donor alive for a transplant operation.
8. Travel expenses, lodging and meals when the Transplant Network Hospital is less than 50 miles from transplant recipient.
9. Charges for personal comfort or convenience items.
10. Charges incurred by more than one Travel Companion.
11. Charges incurred by the transplant recipient and the Travel Companion for transportation, lodging and meals other than what is reasonable and necessary for the treatment plan.
12. Charges in connection with the Travel Benefit that are not incurred for the treatment plan at a Transplant Network Hospital, except travel days.
13. Charges incurred for transportation for the Travel Companion other than the trip required to accompany the transplant recipient to and from the Transplant Network Hospital.
14. Charges for the repair or maintenance of a motor vehicle.
15. Personal expenses incurred to maintain the transplant recipient or the Travel Companion's residence while you and your Travel Companion are traveling to and from the Transplant Network Hospital and during the length of stay. Some examples of these personal expenses include but may not be limited to: child care costs, house sitting costs or kennel charges.
16. Reimbursement of any wages lost by the transplant recipient or the Travel Companion during the treatment plan.

LARGE CASE MANAGEMENT

The Plan provides for Large Case Management. This means that the Plan Sponsor, or Contract Administrator, with the Covered Person's consent, may recommend alternate care and treatment for your chronic or catastrophic Illness or injury and may negotiate with providers for discounted services. In addition, the Plan may elect to offer benefits for services furnished by any provider pursuant to a Plan-approved alternative treatment plan for a Covered Person.

The Plan shall provide such alternative benefits at its sole discretion and only when and for so long as it determines that alternative care services are Medically Necessary and cost effective.

If the Plan elects to provide alternative benefits for a Covered Person in one instance, it shall not be obligated to provide the same or similar benefits for other Covered Persons under the Plan in any other instance, nor shall it be construed as a waiver of the Plan Sponsor's or Contract Administrator's rights to administer the Plan thereafter in strict accordance with its express terms.

LIMITATIONS AND EXCLUSIONS

Except as specifically stated, no benefits shall be payable under this Plan for expenses incurred for:

Air Purification Units - Air conditioners, air-purification units, humidifiers and electric heating units.

Autopsies

Behavior Modification - Charges for hypnotism, acupuncture or any type of goal-oriented or behavior modification therapy, such as to quit smoking or lose weight.

Cosmetic Surgery - Plastic or cosmetic surgery, except for:

- Surgery done to lessen damage caused by an accident or done because of a disorder of normal bodily functions; or
- Surgery and reconstruction on the non-diseased breast to make it equal in size to the diseased breast following reconstructive Surgery on the diseased breast (see Mastectomy under Covered Expenses); or
- Surgery incidental to or following Medically Necessary surgical removal of a body part, or reconstructive surgery due to Illness, injury or other disease of the involved body part; or
- Surgery performed on a Dependent child because of a congenital disease or anomaly which has resulted in a functional defect.

Counseling - Confinement, treatment or service for educational or training problems, learning disorders, marital counseling or social counseling. This exclusion shall not apply to training or educational services provided by a dietician, Physician or an individual working under the direction of a Physician for the treatment of diabetes or cardiac conditions.

Court-ordered Treatment - Any treatment or confinement of a Covered Person in a public or private institution as the result of a court order, except for an initial court ordered exam for a covered Dependent child under age nineteen (19).

Criminal Acts - Any injury resulting from or occurring during the Covered Person's commission or attempt to commit an assault or felony, or any injury resulting from a Covered Person being in an illegal occupation.

Custodial Care - Care primarily for the purpose of meeting personal needs which could be rendered by persons without professional skills or training.

Dental Care - Care or treatment on or to the teeth, alveolar processes, gingival tissue, or for malocclusion, (including orthodontic treatment for TMJ), except for:

- Oral Surgery caused by impacted or unerupted teeth, apicoectomy, gingivectomy or alveolectomy;
- The repair (including replacement) or alleviation of damage to natural teeth caused solely by Accidental Bodily Injury provided such treatment is rendered within 180 days of the accident;
- Hospital charges otherwise covered by the Plan.

Detoxification - Services for detoxification, unless followed by an In-patient stay in a Hospital or residential Chemical Dependency treatment facility or an Out-patient treatment program within fourteen (14) days of the receipt of the detoxification services.

Diagnostic Hospital Admissions - Confinement in a Hospital that is for diagnostic purposes only, when such diagnostic services could be performed in an Out-patient setting.

DNA Analysis - Services for, or related to, DNA analysis for non-medically necessary conditions, except the Plan will cover DNA analysis if there is a documented presence of specific clinical symptoms related to a clearly established disease, and the results of testing will help to establish a definitive diagnosis that will assist in developing a specific clinical treatment plan.

Drugs in Testing Phases - Medicines or drugs which are in the Food and Drug Administration I, II or III testing phases.

Excess Charges - Charges in excess of the Usual and Customary fees for services or supplies provided.

Exercise Equipment - Exercise equipment, vibratory equipment, swimming or therapy pools.

Experimental/Investigational - Services or supplies which are experimental or investigational in nature, as determined by the Food and Drug Administration, or which do not constitute accepted medical practice properly within the range of appropriate medical treatment under the standards of a reasonably substantial, qualified, relevant segment of the medical community, as determined by the Plan.

Fetal Tissue Transplantation - Service for, or related to, fetal tissue transplantation.

Forms Completion - Charges made for the completion of claim forms or for providing supplemental information.

Gene Therapy - Services for, or related to, gene therapy as a treatment for inherited or acquired disorders.

Government-Operated Facilities - Services furnished the Covered Person in any Veteran's Hospital, military Hospital, institution or facility operated by the United States government, or by any State government, or by any agency or instrumentality of such government, for which the Covered Person has no legal obligation to pay, except for services incurred and billed after October 1, 1986, for non-service related disabilities.

Growth Hormone - Services for, or related to, human growth hormone, except for a Covered Person with a documented hormone deficiency due to pituitary origin or for other conditions that the Food and Drug Administration have determined constitute accepted medical practice, and meet Medically Necessary criteria as determined by the Plan.

Health Club - Enrollment in a health, athletic or similar club.

Hearing Aids - Charges incurred for the purchase or fitting of hearing aids; or charges incurred for the cost of surgical implants to stimulate hearing, such as cochlear implants.

Home Health Care - Services of any social worker, transportation services, or any other services not specifically included in the list of Covered Expenses.

Infertility Treatment - Any service or expense for, or related to, infertility treatment including but not limited to:

- Fertility tests
- Fertility drugs
- Reversal of sterilization
- Sperm banking
- Services for or related to assisted reproductive technology (AR) procedures, including but not limited to artificial insemination (AI), intrauterine insemination (IUI), in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT), with or without cryopreservation or frozen embryo transfer

Medically Necessary procedures used to diagnose or treat medical conditions associated with infertility are Covered Expenses.

Maintenance Care - Hospitalization or confinement in a health facility primarily for maintenance or domiciliary care, for rest, to treat or cure chronic pain, or to control or change a patient's environment.

Massage Therapy or Rolfing

Medical Care Outside of the United States - Benefits are payable for treatment received in the United States, Canada, Puerto Rico, and the U.S. Virgin Islands. No benefits are payable if the Covered Person leaves these areas to be treated. If the Covered Person leaves for non-medical reasons, benefits will be paid for an Illness or accident that occurs during the first 120 days away. The 120 day limit will not apply if the Covered Person is away on Employer business, or is a dependent student.

Military Hospital - (see Government-Operated Facilities)

Military Service - Charges for treatment of any Illness contracted while in the military service of any country.

Missed Appointments - Charges for failure to keep scheduled appointments.

Nicotine Addiction

No Charge or No Legal Requirement to Pay - Services for which no charge is made or for which a Covered Person is not required to pay, or is not billed or would not have been billed in the absence of coverage under this Plan.

Nuclear Energy Release - Any Illness resulting from the non-therapeutic release of nuclear energy.

Occupational Injury or Illness - Any Illness for which the Covered Person has or had a right to compensation under any Workers' Compensation or Occupational Disease Law or any other legislation of similar purpose, or Illness which arises from or is sustained in the course of any occupation or employment for compensation, profit or gain.

Other Coverage - Services or supplies which a Covered Person is entitled to have reimbursed by or furnished by any plan, authority or law of any government, governmental agency (Federal or State, Dominion or Province of any political subdivision thereof).

Other Plan Sponsor Plans - Supplies and services to the extent that they have been paid under any Dental, Vision or other Medical type Plan of the Plan Sponsor.

Personal Comfort or Convenience Items - Services or supplies provided for personal comfort and not necessary for treatment of an Illness including, but not limited to, the purchase or rental of telephones, televisions, orthopedic mattresses, allergy free pillows, blankets and/or mattress covers, wigs, non-prescription drugs and medicines, breast pumps, non-hospital adjustable beds, water beds, motorized transportation equipment, elevators, escalators, professional medical equipment (such as blood pressure kits) or supplies or attachments to such equipment.

Pre-existing Conditions - Services, treatment or supplies excluded from coverage subject to the Plan's Pre-existing Conditions Limitation.

Prior Coverages - Services or supplies for which the Covered Person is eligible for benefits under the plan which this Plan replaces.

Relative Care - Any service rendered to a Covered Person by a Relative or anyone who customarily lives in the Covered Person's household.

Reversal of Sterilization

Routine Care - Routine exams, physicals, immunizations, or laboratory procedures not Medically Necessary for Illness except as shown in the Schedule of Benefits.

Self-Procured Services - Charges for services rendered to a Covered Person who is not under the regular care of a Physician, and for services, supplies or treatment, including any period of Hospital confinement, which were/are not recommended, approved and certified as necessary and reasonable by a Physician.

Sex Change Procedures - Sex change counseling, treatment or services incident to intersex Surgery (transsexual operations) or any resulting complications.

Surrogate Parenting Expenses

Telephone Consultations - Charges for telephone consultations by a Physician or other health professional.

Therapy - Vocational, recreational, art, dance or music therapy and therapy which is primarily educational in nature.

Transplants - Confinement, treatment, service, or materials for animal-to-human organ transplant, transplant or implantation within the human body of non-human artificial or mechanical devices designed to replace human organs, or any part thereof, or transplants which are not listed as specifically covered elsewhere in the Plan.

Veteran's Hospital - (see **Government-Operated Facilities**)

Vision Care - Services for, or related to, lenses, frames, contact lenses, and other fabricated optical devices or professional services for the fitting and/or supply thereof, including treatment for refractive errors, such as radial keratotomy. This exclusion shall not apply to aphakia patients and soft lenses and sclera shells intended for the use in the treatment of disease or injury, the initial purchase of glasses or contact lenses following cataract surgery covered under the Plan, or to routine eye exams subject to the limits shown in the Schedule of Benefits.

War - Health impairments resulting from insurrection, war, declared or undeclared, or any act of war and any complications therefrom, or service in the Armed Forces of any country.

Weight Control Programs - Services, supplies or treatment for obesity, weight reduction or weight gain or prescriptive nutritional supplements, minerals or vitamins.

EFFECTS OF OTHER COVERAGE

Coordination of Benefits

If a Covered Person is covered under this Plan and one or more other Plans, as defined below, the benefits payable with respect to the Covered Person under this Plan will be either its regular benefits or reduced benefits which when added to the benefits of the other Plan, will equal 100% of the Allowable Expenses, also defined below.

Plan - The term Plan means any of the following types of coverage providing medical or dental benefits or services:

(a) Group, blanket or franchise insurance coverage;

(b) Any group Hospital service pre-payment coverage; group medical service pre-payment, group practice or other group pre-payment coverage;

(c) Group coverage under labor management trusteed plans, union welfare plans, Employer organization plans or Employee Benefit Plan;

(d) Coverage under governmental programs or coverage required or provided by any statute;

(e) Coverage provided through a school or other educational institution;

(f) Medical coverage provided under "no fault" automobile coverage.

The term Plan will be construed separately with respect to each policy, contract or other arrangement for benefits or services, separately with respect to that portion of a policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits, and separately with respect to that portion which does not reserve that right.

Allowable Expense - Allowable Expense means any Usual and Customary item of expense at least a portion of which is covered under at least one of the plans covering the individual for which claim is made.

When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered to be both an Allowable Expense and a benefit paid.

Claim Determination Period - Claim Determination Period means a Calendar Year or that portion of a Calendar Year during which the individual for whom claim is made has been covered under this Plan.

Coordination of Benefits Provisions - If any individual covered under this Plan is also covered under one or more other plans, the benefits payable with respect to this Plan will be coordinated with benefits payable with respect to all other plans.

This coordination will apply in determining the benefits payable with respect to an individual for any Claim Determination Period, if, for the Allowable Expenses incurred during that period, the sum of the benefits that would be payable under this Plan in the absence of coordination, and the benefits that would be payable under all other plans in the absence of provisions for coordination in those plans would exceed those Allowable Expenses.

When Coordination of Benefits applies to the benefits payable with respect to an individual for any Claim Determination Period, the benefits that would be payable for Allowable Expenses incurred during that period under this Plan in the absence of Coordination of Benefits will be reduced to the extent necessary so that the sum of those reduced benefits and all the benefits payable for those Allowable Expenses under all other Plans will not exceed the total of those Allowable Expenses. Benefits payable under all other Plans include the benefits that would have been payable had the claim been properly made for them.

When Coordination of Benefits operates to reduce the total amount of benefits otherwise payable during any Claim Determination Period with respect to an individual covered under this Plan, each benefit that would be payable in the absence of Coordination of Benefits will be reduced proportionately, and the reduced amount will be charged against any applicable benefit limit of this Plan.

For the purposes of determining the applicability of and implementing the terms of the above provisions of this Plan or any similar provision of another Plan, the Employer or Plan may, without the consent of or notice to any individual, release to or obtain from any insurance company or other organization or individual, any information concerning any individual which the Employer or Plan considers to be necessary for those purposes. Any individual claiming benefits under this Plan will furnish to the Employer or Plan the information that may be necessary to implement the above provisions.

Whenever payments which should have been made under this Plan in accordance with the above provisions have been made under any other Plans, the Employer or Plan will have the right, exercisable alone and in its sole discretion, to pay to any organizations making these payments any amount it determines to be warranted in order to satisfy the intent of the above provisions, and amounts paid in this manner will be considered to be benefits paid under this Plan, and to the extent of these payments, the Employer will be fully discharged from liability under this Plan.

Whenever payments have been made by this Plan, at any time, for Allowable Expenses in a total amount in excess of the maximum amount of payment necessary at that time to satisfy the intent of the above provisions, this Plan will have the right to recover these payments, to the extent of the excess, from among one or more of the following, as this Plan will determine: any individuals to, or for, or with respect to whom, these payments were made, any insurance companies, and other organizations.

The "primary" Plan always pays first. When a Plan does not contain a coordination of benefits provision, it is always the primary Plan. When two or more Plans contain coordination of benefits provisions, the primary Plan is the Plan that covers the person claiming benefits as a member or Employee.

If the patient is a dependent child of parents who are not separated or divorced, the Plan covering the parent whose birth date occurs earlier in the year is primary. If both parents have the same birthday, the Plan which covered the patient longer pays before the Plan which covered the patient for a shorter period of time.

If the patient is a dependent child of parents who are separated or divorced and the court has established that one of the parents is financially responsible for the health care of the child, then the Plan of the parent with such responsibility pays before the Plan of the parent without such responsibility. If financial responsibility for health care has not been established, then the Plan of the parent having custody pays first; then the Plan of the spouse of the parent with custody (the step-parent) pays next; and the Plan of the parent without custody pays last.

The benefits of a Plan which covers an Employee who is neither laid off nor retired, or that Employee's Dependent, are determined before the benefits of a Plan which covers that person as a laid off or retired Employee, or that Employee's Dependent. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

If none of the above rules determine the order of benefits, the benefits of the Plan which covered an Employee, member, or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

SUBROGATION

In the event of any payment of benefits under this Plan for medical or dental charges incurred by a Covered Person and: (a) the charges result from the negligent or intentional act, or failure to act, of any Third Party; (b) the charges are reimbursed, in whole or in part, by a Third Party; or (c) a Third Party is liable for the charges, such benefits shall be subject to reimbursement and the right of subrogation described in this section. For purposes of this section, the term "Third Party" shall mean any person or persons, other than the Covered Person who incurs the charges giving rise to a claim for benefits; other party or parties; firm; corporation; insurer; or other entity or entities.

No benefits will be paid under the Plan for medical or dental charges incurred by a Covered Person if such Covered Person has received payment from the Third Party for past, present or future medical expenses for which the Third Party is or may be liable. Payments made by a Third Party shall be deemed to relate to the Covered Person's medical or dental expenses regardless of whether the payments are denominated as a payment of medical or dental expenses and regardless of whether the Covered Person has been fully compensated. Upon any recovery from a Third Party by or on behalf of a Covered Person, this Plan shall be fully reimbursed to the extent of any such payments made by the Plan to or on behalf of a Covered Person. If any balance then remains from such recovery, it shall be distributed to the Covered Person.

This Plan is subrogated to the extent of any payment or intended payment of benefits by this Plan for health or dental care to the rights of each Covered Person to recovery therefore against any Third Party which is or becomes obligated to pay benefits to the Covered Person, including reasonable expenses and costs incurred by the Plan in effecting any recovery.

The reimbursement and subrogation rights of the Plan shall apply, and be binding upon Covered Persons and their legal representatives regardless of whether: (a) the payment received from the Third Party is the result of a suit, judgment, arbitration award, compromise, settlement, or any other arrangement; (b) a Third Party has admitted liability for the payment; or (c) the payment is characterized as payment for medical claims, personal injury, tort claims, disability, pain and suffering, or otherwise. The Plan's right to reimbursement and subrogation shall be considered a first priority claim against any Third Party before the recovery of any existing claim by or on behalf of the Covered Person, including, but not limited to, any claims for general damages and the Plan may collect from the proceeds of any settlement or judgment recovery or any other recovery regardless of whether the Covered Person has been fully compensated. Any amount recovered by or on behalf of the Covered Person shall be deemed to be held in trust for the Plan under the provisions of this section.

The Plan shall not be liable for any expenses, including attorneys fees, in connection with the recovery of monies from any Third Party unless the Plan shall have agreed in writing to bear a specified proportion of such expense.

The Plan may, at its option, take such action as it may consider necessary and appropriate to preserve its rights under the provisions of this section including, but not limited to, bringing suit in the Covered Person's name or intervening in any lawsuit the Covered Person may have commenced against a Third Party. The Plan may collect from the proceeds of any legal action, whether by judgment or settlement, such amounts as may be recovered by or on behalf of the Covered Person, regardless of whether the Covered Person has been fully compensated.

Prior to payment of any charges under this section, the Plan may require execution by the Covered Person of a subrogation agreement. Any such agreement shall not reduce, limit, or extinguish rights of the Plan under this section and any rights of the Plan under any such agreement shall be considered to be cumulative with the Plan's rights under this section. Similarly, the failure of the Plan to obtain a subrogation agreement shall in no way diminish the Plan's right to subrogation. In the event the Covered Person does not execute a subrogation agreement as required by the Plan or does not make suitable arrangements whereby, in the Plan's sole discretion, the Plan's subrogation rights are fully protected, the Plan may withhold the payment of any benefits.

If the Covered Person fails to reimburse the Plan as provided in this section, the Plan may offset any future benefits otherwise payable to the Covered Person until the amount required to be reimbursed under this section is fully offset.

In the event a Covered Person commences a lawsuit against a Third Party, or enters into settlement negotiations with a Third Party, with respect to a claim for which the Plan has a right of subrogation under this section, such Covered Person shall immediately notify the Plan in writing.

The right of reimbursement and subrogation described in this section shall extend to any recovery from or liability on the part of the Covered Person's insurer including, but not limited to, any right of recovery or liability due to no-fault, uninsured or underinsured coverages.

IMPORTANT NOTICE FOR INDIVIDUALS ENTITLED TO MEDICARE

Medicare means Title XVIII, Parts A and B of the Social Security Act.

If you are eligible for Medicare benefits, but not enrolled, benefits under this Plan will be paid as if you had enrolled for Medicare.

IF YOUR EMPLOYER EMPLOYS 20 OR MORE EMPLOYEES, and you are age 65 or over and are eligible for Medicare, you have the option of either:

1. Continuing coverage under this Plan, in which case Medicare benefits would be secondary to this Plan; or

2. Electing Medicare as your primary coverage, in which case no benefits would be payable under this Plan.

IF YOUR EMPLOYER EMPLOYS FEWER THAN 20 EMPLOYEES, and you are age 65 or over and are eligible for Medicare, the benefits of this Plan are secondary to Medicare.

TERMINATION OF COVERAGE

Employee Coverage Termination

An Employee's coverage under this Plan shall terminate, except as provided in the Plan's Coverage Continuation Option, upon the earlier of:

- The date the Plan terminates;
- The date of Employee's entry into the Armed Forces of any country, except for temporary active duty of thirty-one (31) days or less;
- At midnight on the last day of the month during which the covered Employee leaves or is dismissed from the employment of the Employer or is retired or pensioned or ceases to be engaged in Active Employment in the conduct of and on the premises of the Employer's business; unless the Employee is on an Employer approved leave as may be provided for by the federal Family and Medical Leave Act of 1993;
- The date beginning the period for which the Employee has failed to make any required contribution for coverage.

Dependent Coverage Termination

A Dependent's coverage under this Plan shall terminate, except as provided in the Plan's Coverage Continuation Option, upon the earlier of:

- The date the Plan is terminated or is modified to terminate Dependent coverage;
- The date the Employee's coverage terminates;
- At midnight on the last day of the month during which the Dependent ceases to be an eligible Dependent by Plan definition;
- At midnight on the last day of the month during which the Dependent ceases full-time school attendance **except** that:
    - If cessation is due to school vacation (either summer vacation or semester/quarter chosen by the Dependent during the school year), Dependent status shall terminate on the date the school reconvenes if attendance does not resume; or
    - If cessation is due to disability which prevents full-time school attendance, Dependent status shall terminate on the last day of the quarter/semester in which the disability occurred.

- The date beginning the period for which the Employee has failed to make any required contribution for Dependent coverage;
- The date of the Dependent's entry into the Armed Forces of any country, except for temporary active duty of thirty-one (31) days or less;
- The date the Dependent becomes eligible for coverage under this Plan as an Employee.

Extended Coverage Options

Refer to Coverage Continuation Option

COVERAGE CONTINUATION OPTION

Introduction

You are receiving this information as a participant in the Farmers Cooperative Association group health plan. This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. **This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The Plan Administrator is Farmers Cooperative Association, 1206 South Douglas Hwy., Gillette, WY 82716, 607-682-4468. Sheffield, Olson & McQueen, Inc. is not the Plan Administrator or a fiduciary of the Plan. The third party administrator's address and telephone number are the following:

Sheffield, Olson & McQueen, Inc.
2145 Ford Parkway, Suite 300
St. Paul, Minnesota 55116-1914
(651) 695-2500 or 1-800-486-7664

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed later in this section. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". Only qualified beneficiaries may elect to continue their group health plan coverage. A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of Employees, and Dependent children of Employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment, if applicable, and special enrollment rights. Specific information describing the coverage to be continued under the Plan is contained elsewhere in this document.

If you are an Employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced, or

2. Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an Employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

1. Your spouse dies;

2. Your spouse's hours of employment are reduced;

3. Your spouse's employment ends for any reason otner than his or her gross misconduct;

4. Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or

5. You become divorced or legally separated from your spouse. If an Employee cancels coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the administrator within 60 days after the divorce or legal separation and can establish that the Employee canceled the coverage earlier in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation.

Your Dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

1. The parent-Employee dies;

2. The parent-Employee's hours of employment are reduced;

3. The parent-Employee's employment ends for any reason other than his or her gross misconduct;

4. The parent-Employee becomes enrolled in Medicare (Part A, Part B, or both); or

5. The parents become divorced or legally separated; or

6. The child stops being eligible for coverage under the Plan as a "Dependent child".

Notifying the Plan Administrator of Qualifying Events

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Employee, or enrollment of the Employee in Medicare (part A, Part B, or both), the Employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events.

For the other qualifying events (divorce or legal separation of the Employee and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator in writing within 60 days after the later of the qualifying event or loss of coverage using the procedures described below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, any spouse or dependent child who loses coverage will NOT BE OFFERED THE OPTION TO ELECT CONTINUATION COVERAGE.

Notice Procedures

Any notice that you provide must be in writing. Oral notice, including notice by telephone, is not acceptable. Your must mail or fax your notice to COBRA Administrator at the following address:

Sheffield, Olson & McQueen, Inc.
2145 Ford Parkway, Suite 300
St. Paul, Minnesota 55116-1914
(651) 695-2500 or 1-800-486-7664
fax (651) 695-1646

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state the name of the Plan, the name and address of the Employee covered under the Plan, and the name(s) and address(es) of the qualified beneficiary(ies). Your notice must also name the qualifying event and the date it happened.

The Plan's form of Notice of Qualifying Event should be used to notify COBRA Administrator or the Plan Administrator of a qualifying event. A copy of this form can be obtained from the Plan Administrator. If the qualifying event is a divorce, your notice must include a copy of the divorce decree.

Your notice of a second qualifying event also must name the event and the date it happened. If the qualifying event is a divorce, your notice must include a copy of the divorce decree.

Your notice of disability must also include the name of the disabled qualified beneficiary, the date when the qualified beneficiary became disabled and the date the Social Security Administration made its determination. Your notice of disability must include a copy of the Social Security Administration's determination.

The Plan's form of Notice by Qualified Beneficiary should be used to notify COBRA Administrator or the Plan Administrator of a second qualifying event, a disability determination or a determination that a qualified beneficiary is no longer disabled. A copy of this form can be obtained from the Plan Administrator.

Electing COBRA Continuation Coverage

Once the Plan Administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date Plan coverage would otherwise have been lost.

Each qualified beneficiary has an independent right to elect continuation coverage. For example, both the Employee and the Employee's spouse may elect continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their Dependent children only. **A qualified beneficiary must elect coverage in writing within 60 days of being provided a COBRA election notice, using the Plan's Election Form and following the procedures specified on the Election Form.** A copy of the Plan's Election Form may be obtained from the COBRA Administrator or the Plan Administrator. Your written notice must be provided to the COBRA Administrator or the Plan Administrator at the address provided on the Plan's Election Form. If you mail your election, it must be postmarked no later than the last day of the 60-days election period. **If you or your spouse or Dependent children do not elect continuation coverage within the 60-day election period, YOU WILL LOSE YOUR RIGHT TO ELECT CONTINUATION COVERAGE.** A qualified beneficiary may change a prior rejection of continuation coverage any time until the end of the 60-day election period, in writing, by using the Election Form and following the procedures specified on the Election Form.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Length of COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, enrollment of the Employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a Dependent child losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are three ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

An 11-month extension of coverage may be available if any of the qualified beneficiaries in your family is disabled. All of the qualified beneficiaries who have elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. The Social Security Administration (SSA) must determine that the qualified beneficiary was disabled at some time during the first 60 days of continuation coverage, **and you must notify the Plan Administrator of that fact in writing, using the procedures specified in the section entitled "Notice Procedures", within 60 days of the SSA's determination and before the end of the first 18 months of continuation coverage. If these procedures are not followed or if a written notice of a disability is not provided to the COBRA Administrator or the Plan Administrator within the required period, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA CONTINUATION COVERAGE.**

If the qualified beneficiary is determined by the SSA to no longer be disabled, you must notify COBRA Administrator or the Plan Administrator of that fact within 30 days of the SSA's determination, using the procedures specified in the section entitled "Notice Procedures". COBRA coverage for all qualified beneficiaries will terminate as of the first day of the month that is more than 30 days after the SSA's determination that the qualified beneficiary is no longer disabled. **The plan reserves the right to retroactively cancel COBRA coverage and will require reimbursement of all benefits paid after the first day of the month that is more than 30 days after the SSA's determination that the qualified beneficiary is no longer disabled.**

Second qualifying event extension of 18-month period of continuation coverage

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months on continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events include the death of a covered Employee, divorce or legal separation from the covered Employee, the covered Employee enrolls in Medicare (Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a Dependent under the Plan.

Upon the occurrence of a second qualifying event, **you must notify COBRA Administrator or the Plan Administrator of that fact in writing within 60 days after the second qualifying event occurs using the procedures specified in the section entitled "Notice Procedures". If these procedures are not followed or if a written notice of a second qualifying event is not provided to the Plan Administrator within the required period, THEN THERE WILL BE NO EXTENSION OF COBRA CONTINUATION COVERAGE DUE TO A SECOND QUALIFYING EVENT.**

Medicare extension for spouse and Dependent children

If a qualifying event that is a termination of employment or reduction of hours occurs within 18 months after the covered Employee becomes entitled to Medicare, then the maximum coverage period for the spouse and Dependent children will end three years from the date the Employee became entitled to Medicare (but the covered Employee's maximum coverage period will be 18 months).

Termination of COBRA Continuation Coverage Before the End of the Maximum Coverage Period

Continuation coverage will be terminated before the end of the maximum period if (1) any required premium is not paid on time; (2) after electing COBRA coverage, a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary; (3) after electing COBRA coverage, a qualified beneficiary enrolls in Medicare; or (4) the employer ceases to provide any group health plan for its Employees. Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

You must notify COBRA Administrator or the Plan Administrator in writing within 30 days if, after electing COBRA coverage, a qualified beneficiary becomes covered under another group health plan or enrolls in Medicare Part A or B. You must use the notice procedures specified in the box above entitled "Notice Procedures". The Plan reserves the right to retroactively cancel COBRA coverage and in that case will require reimbursement of all benefits paid after the date of commencement of other group health plan coverage or Medicare entitlement.

Cost of Continuation Coverage

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% of the cost to the group health plan (including both employer and Employee contributions) for coverage of a similarly-situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150%).

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

Payment for Continuation Coverage

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment for continuation coverage with the Election Form. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) **If you do not make your first payment for continuation coverage within that 45 days, you will lose all continuation coverage rights under the Plan.**

Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact the COBRA Administrator or the Plan Administrator to confirm the correct amount of your first payment.

Your first payment for continuation coverage should be sent to the address indicated on the election notice provided at the time of your COBRA qualifying event.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation coverage are due by the first day of the month for that month's coverage. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. The Plan will not send periodic notices of payments due for these coverage periods. You must make your payment by the due date or within the grace period (discussed below).

Periodic payments for continuation coverage should be sent to the address indicated on the election notice provided at the time of your COBRA qualifying event.

Grace period for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each coverage period so long as payment for that coverage period is made before the end of the grace period for that payment.

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

More Information About Individuals Who May be Qualified Beneficiaries

Children born to or placed for adoption with the covered Employee during COBRA period

A child born to, adopted by or placed for adoption with a covered Employee during a period of continuation coverage is considered to be a qualified beneficiary provided that, if the covered Employee is a qualified beneficiary, the covered Employee has elected continuation coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the Employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

Alternate recipients under QMCSOs

A child of the covered Employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Employer during the covered Employee's period of employment with the Employer is entitled to the same rights under COBRA as a Dependent child of the covered Employee, regardless of whether that child would otherwise be considered a Dependent.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact COBRA Administrator or the Plan Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's web site at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

CLAIM PROCEDURES

DEFINITIONS

Claim - A Claim is any request for a Plan benefit or benefits, made by you or your authorized representative, that complies with the Plan's reasonable procedure for filing benefit Claims. A Claim includes a request for benefits, or a request for Pre-admission, Concurrent or Retrospective review in accordance with the terms of the Plan. A request exclusively for determination of eligibility is not considered a Claim. A purchase using a Prescription Drug Card is not considered a Claim.

Post-service Claim - A Claim that is made after the medical service is provided to the Covered Person is a Post-service Claim. A Claim which is not a Pre-service or an Urgent Care Claim is a Post-service Claim. For the purposes of this Plan, all Claims other than Pre-admission Review for Hospital confinements or Partial Hospitalizations are Post-service Claims. A Retrospective Review of a Hospital Confinement is a Post-service Claim.

Pre-service Claim - A Claim which must be approved by the Plan before you incur the charge is a Pre-service Claim. Any Claim for a benefit under this Plan which conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care is a Pre-service Claim. For the purposes of this Plan, an In-patient Hospital confinement or Partial Hospitalization, which requires Pre-admission Review, is a Pre-service Claim.

Urgent Care Claim - A Hospital confinement or Partial Hospitalization which requires urgent admission is an Urgent Care Claim. An admission is considered *urgent* if delay could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the Covered Person to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A Physician with knowledge of the Covered Person's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, may make the determination.

A Post-service Claim is never an Urgent Care Claim.

PROCEDURES FOR FILING OF BENEFIT CLAIMS

Post-service Claim

1. A Post-service Claim is filed in accordance with the Plan's procedures for filing of benefit Claims if all the following requirements are met:
   a. The Claim is submitted to the Plan Administrator or its agents, the Contract Administrator or Preferred Provider Network, in written or electronic form;
   b. The Claim is received within 90 days of the date of loss. If the Claim was not received within the 90 day limit, you may furnish proof as soon as reasonably possible. However, a Claim cannot be received later than one year after the date of loss, except in a case of absence of legal capacity of the Covered Person.

2. If submitted in written form, the Claim must contain the following information:
   a. Employee's name, group number and Social Security Number;
   b. Patient's name;
   c. Provider's name and address;
   d. Date(s) expense(s) incurred;
   e. Itemization of charges;
   f. Description of Services using codes from CPT (American Medical Association Current Procedural Terminology) or HCPCS (HCFA Common Procedure Coding System);
   g. Diagnosis using codes from ICD-9-CM (Ninth Edition International Classification of Diseases);
   h. The provider's TIN (Tax Identification Number);
   i. Drug Claims should include the name of the drug, the prescription number and the name of the prescribing Physician; and
   j. If payment is made directly to a provider, a signed Assignment of Benefits.

3. Written Claims should be submitted as soon as possible after expenses are incurred to:

Sheffield, Olson and McQueen, Inc.
P.O. Box 16608
St. Paul, Minnesota 55116-0608

4. If submitted in electronic form, the Claim must be filed in accordance with transaction standards set by the federal government as part of the Health Insurance Portability and Accountability Act (HIPAA).

5. Information regarding other coverage must be provided by the Employee at intervals determined by the Plan. If the patient has other coverage, the name, address and phone number of other carriers and the effective date and termination date of other coverage must be provided. If the patient does not have other coverage, a statement that there is no other coverage must be provided.

6. If coverage under this Plan is secondary to other coverage, the other carrier's Explanation of Benefits (EOB) must be provided.

7. If the Claim is subject to a Pre-existing Conditions Limitation, the Employee must provide the Plan with the names and addresses of all Physicians who have treated the patient during the Pre-existing Condition period, the name of each medication which the patient took during the Pre-existing Condition period, and the diagnosis for which the medication was prescribed. Each Physician who has treated the patient within the Pre-existing Condition period must provide the Plan with a statement of the services rendered, dates, diagnosis for each date, medications prescribed and names of any referral physicians.

8. The Plan must be provided with sufficient information to determine whether a Claim is correctly covered under this Plan. In the case of an accident, for example, this means making a determination as to whether the Claim is work related, or whether another form of insurance or other party is responsible for all or part of the Claim.

9. The Plan must be provided with sufficient information to determine whether a Claim is Medically Necessary.

10. If there is a possibility of a Claim from a plan that is not a group medical plan, the Plan must be provided with a signed, dated Subrogation Statement.

11. The Plan must be provided with sufficient information to determine that the patient is a Covered Person under the terms of the Plan (for example, proof of school attendance for a covered Dependent child over age 18).

12. The Plan may request any other information which it deems necessary to process a Claim.

Pre-service Claim

A Pre-service Claim is filed in accordance with the Plan's procedures for filing of benefit Claims if all the following requirements are met:

1. The Medical Management Services Program is called at least 72 hours prior to the start of the confinement or on the next business day (whichever is later);
2. The caller provides all the following information:
    a. Employee's name, group number and Social Security Number;
    b. Patient's name;
    c. Date(s) of expected confinement;
    d. Name, address and phone number of facility where patient is expected to be confined;
    e. Name of admitting Physician; and
3. Complete Clinical Information is received from the admitting Hospital.

Urgent Care Claim

An Urgent Care Claim is filed in accordance with the Plan's procedures for filing of benefit Claims if all the following requirements are met:

1. The Medical Management Services Program is called within 48 hours after the start of the confinement or on the next business day (whichever is later);
2. Information is received from the claimant or Physician regarding the medical circumstances that give rise to a need for expedited processing of the Claim;
3. The caller provides all the following information:
    a. Employee's name, group number and Social Security Number;
    b. Patient's name;
    c. Name and phone number of facility where patient is confined or expected to be confined; and
4. Complete Clinical Information is received from the admitting Hospital.

Concurrent Care Claim

A Concurrent Care Claim is filed in accordance with the Plan's procedures for filing of benefit Claims if all the following requirements are met:

1. The Medical Management Services Program is called at least 24 hours before the approved days expire;
2. The caller provides all the following information:
    a. Employee's name, group number and Social Security Number;
    b. Patient's name; and
3. Complete Clinical Information is received from the admitting Hospital.

BENEFIT DETERMINATION PROCEDURES

The Plan Administrator has designated a Contract Administrator for the purposes of evaluating Claims reimbursement under the Plan.

Required Timeframe

The Contract Administrator will decide your Claim within a reasonable time, not longer than:

For Urgent Care Claim –	72 hours after it is received. No extensions are available.
For Pre-service Claim –	15 days after it is received. This time period may be extended for an additional 15 days for matters beyond the control of the Plan Administrator, including cases where Claim information is incomplete.
For Post-service Claim –	30 days after it is received. This time period may be extended for an additional 15 days for matters beyond the control of the Plan Administrator, including cases where Claim information is incomplete.
For Concurrent Care Claim –	24 hours after it is received, if request is made at least 24 hours before the approved days expire. No extensions are available. If the request is not made 24 hours before the approved days expire, the Claim becomes an *Urgent Care* Claim.

If a Claim is incomplete, time is "tolled" (i.e. not counted) from the date the Plan requests additional information, until such additional information is received.

For the purposes of this Plan, a Claim is considered to be "decided" as follows:

- A Pre-service, Urgent Care or Concurrent Care Claim is considered *"decided"* when it is certified by the Medical Management Services Program.
- A Post-service Claim is considered *"decided"* when the Contract Administrator generates an Explanation of Benefits (EOB).

The Medical Management Program evaluates your care to determine Medical Necessity. Plan benefits are based on Medical Necessity. However, nothing in these Benefit Determination Procedures prohibits you from obtaining treatment that you and your physician deem to be necessary.

Notice of Extension – Post-service Claim

If a Post-service Claim is incomplete, the Plan will notify you of the need for additional information within 30 days of the date the incomplete Claim is received.

You are allowed up to 45 days to submit additional information to complete the Claim. A second request for the missing information will be sent 21 days after the first request.

If you do not respond within 45 days of the date the Plan requests additional information, the Claim is automatically denied.

The Plan Administrator or Contract Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide your Claim.

Notice of Extension – Pre-service or Urgent Care Claim

If a Pre-service or Urgent Care Claim is incomplete, the Plan will notify you of the need for additional information as soon as possible after the incomplete information is received. If you do not complete the Claim before the admission date, the rules governing Post-service Claims apply.

Notice of Adverse Benefit Determination

If your Claim is denied, in whole or in part, you will be furnished with a written notice of adverse benefit determination, which provides the following information:

1. The specific reason or reasons for the denial;
2. Reference to the specific Plan provision on which the denial is based;
3. A description of any additional material or information necessary for you to complete your Claim and an explanation of why such material or information is necessary; and
4. Appropriate information as to the steps to be taken if you wish to appeal the Claim determination, including your right to submit written comments and have them considered, your right to review (on request and at no charge) relevant documents and other information, and your right to file suit under ERISA with respect to any adverse determination after appeal of your Claim.

Assignments to Providers

All Covered Expenses reimbursable under the Plan will be paid by the Plan to the covered Employee except that assignment of benefits to Hospitals, Physicians or other providers of service will be honored.

The Plan may pay benefits directly to Preferred Providers.

Reimbursements

Whenever any benefit payments which should have been made under this Plan have been made by another party, the Plan Administrator or its agent, the Contract Administrator, shall be authorized to pay such benefits to the other party; provided, however, that the amounts so paid will be deemed to be benefit payments under the Plan, and the Plan shall be fully discharged from liability for such payments to the full extent thereof.

Right of Recovery

Whenever any benefit payments have been made by the Plan in excess of the maximum amount required under the Plan for Covered Expenses, the Plan shall have the right to recover all such excess amounts from any persons, insurance companies or other payees, and the Employee or Dependent shall make a good faith attempt to assist the Plan Administrator or its agent, the Contract Administrator, in such recovery.

Physical Examination and Autopsy

The Plan, at its own expense, shall have the right and opportunity to examine a Covered Person whose Illness or injury is the basis of a claim when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death, where it is not forbidden by law.

APPEALING A CLAIM

If your Claim is denied in whole or in part, you may appeal to the Plan Administrator or its agent, the Contract Administrator, for a review of the denied Claim. Your appeal must be made in writing within 180 days of the Plan Administrator's initial notice of adverse benefit determination. If you do not appeal on time, you will lose your right to appeal, and consequently, your right to file suit under ERISA. Exhausting your Plan's internal administrative appeal rights is generally a prerequisite to bringing a suit under ERISA.

Your written appeal should state the reasons that you feel your Claim should not have been denied. It should include any additional facts and/or documents that you feel support your Claim. You may also ask additional questions and make written comments, and you may review (on request and at no charge) documents and other information relevant to your appeal. The Plan Administrator or its agent, the Contract Administrator, will review all written comments you submit with your appeal.

Review of Appeal

The Plan Administrator or its agent, the Contract Administrator, will review and decide your appeal within a reasonable time, not longer than 60 days after it is submitted, and will notify you of its decision in writing. The individual who decides your appeal will not be the same individual who decided your initial Claim denial and will not be that individual's subordinate. The Plan Administrator or its agent, the Contract Administrator, may secure independent medical or other advice and require such other evidence as it deems necessary to decide your appeal, except that any medical expert consulted in connection with your appeal will be different from any expert consulted in connection with your initial Claim. (The identity of a medical expert consulted in connection with your appeal will be provided.) If the decision on appeal affirms the initial denial of your Claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

1. The specific reason or reasons for the denial;
2. Reference to the specific Plan provision on which the denial is based;
3. A statement of your right to review (on request and at no charge) relevant documents and other information;
4. If the Plan Administrator relied on an "internal rule, guideline, protocol, or other similar criterion" in making the decision, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and
5. A statement of your right to bring suit under ERISA §502(a).

YOUR ERISA RIGHTS

As a participant in this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

Receive Information about Your Plan and Benefits

ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

ERISA provides that all Plan Participants shall be entitled to:

- Continue health care coverage for a Plan Participant, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

- Reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under this group health Plan, if an Employee or Dependent has Creditable Coverage from another plan. The Employee or dependent should be provided a certificate of Creditable Coverage, free of charge, from the group health plan when coverage is lost under the plan, when a person becomes entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if a person requests it before losing coverage, or if a person requests it up to 24 months after losing coverage. Without evidence of Creditable Coverage, a Plan Participant may be subject to a Pre-Existing Conditions exclusion for 12 months (18 months for Late Enrollees) after the Enrollment Date of coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee Benefit Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If a plan participant's claim for a benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision, without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and to pay the plan participant up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

The court will decide who should pay the court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with your Questions

If you have any questions about your Plan, you should contact the plan administrator.

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Contract Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquires, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

EXHIBIT B

Neuro-Spine

John H. Schneider, MD
Harley Morrell PA-C

2877 Overland Avenue
Suite C
Billings, MT 59102
Phone 406-651-8197
Fax 406-651-8196

424 Yellowstone Avenue
Suite 140
Cody, WY 82414
Phone 307-587-0777
Fax 307-587-0779

07/18/11

Barbara Swanson
Technical Analysis SOM1
2145 Ford Parkway, Suite 300
St. Paul, MN 55116-1912

RE: DUFFY, STEVEN
DOB: Group # 593
Farmer's Cooperative Association
ID # 593991064
Surgery Date: 5/09/11

Dear Ms. Swanson:

I received your letter as dated June 29, 2011. You have all medical records available to you on Mr. Steven Duffy. Our documentation clearly indicates the attempted conservative management of Mr. Duffy's pathology, failure of that management, and surgical indications from that. Based upon the standards set forth by American Association Neurological Surgeons, Spine Section Neurological Surgeons, and National Association of Spine Surgeons, Mr. Duffy met all of the criteria for surgical intervention for failure of conservative modalities. The reviewer for this case denying the claim clearly has the vested interest of the organization, Farmer's Cooperative Association. Also, my office goes through an extensive preauthorization process prior to any surgical intervention on any patient.

It should be noted, therefore, that it will be our strong recommendation that Mr. Duffy immediately contacts an attorney to both file a lawsuit against Farmer's Cooperative Association for bad faith in the administration of benefits related to his healthcare, duress, and inappropriate practice of medicine by a nonmedical association. Simultaneously, we would strongly suggest Mr. Duffy, during the discovery progress, file a medical malpractice lawsuit against the reviewer of this claim who clearly is disregarding the clear indications and the patient suffering, such as Mr. Duffy. These insurance companies who have "curbside consultation" by providers adjudicating medical care is unconscionable and disassociates patients suffering relative to their disease process. In this regard, the physician provider doing the review directly assumes all liability associated with the pain and suffering associated with the patient.

I will provide expert medical testimony against that reviewing provider. As a Board Certified Spine Fellowship Trained Neurosurgeon with three previous academic appointments in both neurosurgery and orthopedic spine surgery, I will look forward and relish the opportunity to demonstrate in a court of law the inappropriateness and incompetence of any provider who would review Mr. Duffy's medical history, his images, and refuse to allow him standards of medical care appropriate for his disease process. We look forward to assisting Mr. Duffy in his pursuit and adjudication of justice.

Best regards,

John H. Schneider, MD
Diplomate, American Board of
Neurological Surgery

cc: Mr. Steven Duffy

EVM:32 D: 2011-07-15 08:44.00
56130 T: 2011-07-18 14:30:00